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RISING HEALTH CARE COSTS: ARE THEY REALLY MAKING IT HARDER FOR U.S. FIRMS TO COMPETE?

HEARING

BEFORE THE

JOINT ECONOMIC COMMITTEE
CONGRESS OF THE UNITED STATES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

MAY 23, 1990

Printed for the use of the Joint Economic Committee

U.S. GOVERNMENT PRINTING OFFICE

33-179 WASHINGTON : 1990

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

J841-26

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RISING HEALTH CARE COSTS: ARE THEY REALLY MAKING IT HARDER FOR U.S. FIRMS TO COMPETE?

WEDNESDAY, MAY 23, 1990

CONGRESS OF THE UNITED STATES,
JOINT ECONOMIC COMMITTEE,
Washington, DC.

The committee met, pursuant to notice, at 10 a.m., in room 2257, Rayburn House Office Building, Hon. Lee H. Hamilton (chairman of the committee) presiding.

Present: Representatives Hamilton, Obey, Scheuer, and Snowe; and Senator Bryan.

Also present: David Podoff, Carl Delfeld, and Scott Borgemenke, professional staff members.

OPENING STATEMENT OF REPRESENTATIVE HAMILTON, CHAIRMAN

Representative HAMILTON. The Joint Economic Committee will come to order.

This morning we will examine the effects of rising health care costs on the competitiveness of U.S. firms.

A number of American industries argue that they are at a competitive disadvantage because our health insurance plans are employment based, and because U.S. per capita health costs are significantly higher than in other industrialized countries. Some economists disagree, asserting that the health care costs are absorbed as part of the overall compensation package.

The relationship between health care costs and competitiveness raises basic questions about the method of financing health care in the United States. To try to understand this relationship, the process of determining labor compensation in both the short and long run should be explored. In addition, the implications for competitiveness, of proposals that increase access to health care by mandating employer-provided health insurance, need to be evaluated.

Finally, irrespective of the outcome of the debate on the relationship between rising health care costs and competitiveness, there is growing recognition that reforms that expand access to health care must go hand in glove with efforts to make the health care system more cost effective.

To help evaluate these issues, I am very pleased to welcome the following distinguished witnesses: Uwe E. Reinhardt, James Madison Professor of Political Economy at Princeton University; Walter B. Maher, director of Federal relations, Human Resources Office,

Chrysler Corp.; Paul H. O'Neill, chairman and chief executive officer of ALCOA.

To assure adequate time for questions and discussion, I would appreciate it if you would limit your opening comments to about 10 minutes. Your prepared statements, of course, will be entered into the record in full.

Mr. Reinhardt, you may begin, sir.

STATEMENT OF UWE E. REINHARDT, JAMES MADISON PROFESSOR OF POLITICAL ECONOMY, PRINCETON UNIVERSITY

Mr. REINHARDT. Thank you, Mr. Chairman. It is a privilege and a pleasure to appear before this committee to explore an issue that has been discussed in the press and in health policy and has confused many people, including, I am sure, myself.

The first question I would like to address is this: Does spending by American business on health care for employees impair these firms' competitiveness in their product markets? In order to get at that problem, we can decompose that question into four subquestions, the first one being: Is the American health care system wasteful in the sense that some of the productive resources it uses would create greater well-being if we shifted them to other sectors of the economy?

I raise that question because business executives who complain about health care costs usually allude to the waste in the American health care system. Now, the answer to that question does appear to be: "Yes, there is waste." There is mounting evidence of unnecessary surgery in this country. For example, I think no other country in the OECD wastes as much on paper to process health care as we do. I think if we had a more efficient insurance system, we could probably save 8 to 10 percent of health expenditures, just on the paperwork.

There is, we can all agree, no question the answer to this first question is: "Yes, there is waste in American health care." But then comes question No. 2: Is that then the problem American business executives are complaining about? In other words, if we eliminated that waste, would their problem then be solved? The answer to that question seems to me to be no.

Put the case that we could eliminate all waste in American health care. With enormous efforts, suppose that we could get health spending down to only 9.5 percent of the GNP from the 11.1 percent now. Do we then believe that Chrysler, for example, would produce for us a Miata? Do we believe that Kodak would again produce cameras of the quality of a Minolta? Do we believe that the RCA Corp. would design and produce a video camera actually made in the U.S.A. rather than merely importing them from Japan and just sticking their RCA label on Japanese-made VCR's?

My answer would be: "No." The problem that U.S. business cannot compete with foreign products has to do with many other factors, among them product design and, among them, production costs in general; including the opulent life style of American managers.

The third question I would like to raise is this: Supposing waste were really not the chief culprit, but that the chief culprit is our

habit of financing health care through the payroll expense line of business rather than through taxes. Does the fact that health care goes through payroll expense make American business noncompetitive?

Intuitively, one would have the feeling, "Yes, that must be so." But as one thinks about it more, it becomes hard to believe how this could be so. The price of labor in the labor market is total compensation including fringe benefits. That is the price that equilibrates the demand for and supply of labor.

Now, as long as fringe benefits are voluntarily offered by business, they are really part of the bargain between labor and management. Management and labor can decide to put some of that total compensation into fringes, but that means that there will be then less to put into cash wages. In a well-functioning labor market fringe benefits and cash wages are substitutes for one another.

Suppose again we got health care costs down from 11.1 percent of the GNP to 9.5 percent. I would project that most of those savings would just go in added cash wages for workers or for executives, or for other expenses. It's hard to believe that product prices would fall, for example, that Chrysler would cut the price of its cars if its health expenditures would go down.

So the answer to the third question, in my view is: "No, there is no reason why health care costs per se should price American business out of the international markets—unless American business executives choose to price themselves out of those markets come hell or high water.

My fourth and final question is this: If it really is true that their outlays on health care does not make American business noncompetitive, if I could make that argument stick, doesn't that then really make the case for mandatory employer-paid health insurance? Here I would argue "No." There is a crucial difference between offering health insurance voluntarily—where it's a voluntary deal between labor and management—and the Government to mandate health insurance, in which case we are really talking about a tax, and in particular we are talking about a head tax that is independent of the income of the worker.

If you mandate health insurance upon small business firms who have low-income employees, these small business firms might try to pass these costs forward through higher prices. But if they could not do that, they would then shift the costs backward to their employees by paying lower cash wages, in which case you actually have put a head tax on the very people whom you wanted to protect.

So I do not believe it is mutually inconsistent to argue, one, that health spending per se does not make business noncompetitive in the product market, and two, there are sound arguments against mandating business of all sizes to offer health insurance to their employees. I have actually in the literature held both positions, and I am willing to defend both propositions at once.

Now, having said all this, one must then ask: Does the Congress owe business any form of relief with health care costs? I would argue "No." I would argue that most of the financial problems besetting American health care today are really the making of the

rigid ideology of American business executives and of the inconsistent decisions they have based on that ideology.

It was business who, in World War II, decided to evade Government strictures on wages by offering fringe benefits. It was business who has, to this day, insisted on shielding these fringe benefits, which is a form of income, from taxation, biasing the worker's choice to that health insurance. It is business that, to this day, has literally surrendered the key to its treasury to the providers of health care. And it is business that to this day insists that the "market" can best regulate the American health sector.

For instance, in New York, I will bet you ALCOA still pays surgeons $8,000 to $10,000 for a coronary bypass. The Physician Payment Review Commission, Harvard, and the AMA jointly, in the resource-based relative values scale, has concluded that something between $3,000 on average would be more appropriate. And perhaps somewhat more in high-cost New York. But not $8,000 to $10,000. Any yet, I would predict that when Medicare introduces this fee schedule, ALCOA will continue to pay the $8,000 and $10,000 it probably now pays in New York. That is what puzzles me. Why do American business firms pay these higher fees? Why will they be doing that, as I predict, and yet come before the Congress complaining that they cannot compete because health care costs are too high?

If American business really wants relief in health care costs, my preferred strategy would be to let business for some time wrestle with the problem it created. After all, if the Government jumped in too soon to help business, Government would then bear all the blame for anything that might go wrong, as is usually the case.

The proper strategy is to make business, first of all, confront in a very painful way, for some 5 years or so, the agony that it unleashed in health care. Maybe then the ideological basis of business will cease to dominate their thinking on health care and they will be able and willing to come forth with something more practical.

Let me close with the following hypothetical: Suppose President Bush invited a random sample of 100 business executives from the Business Roundtable to spend a week in the Willard Hotel. Let's be generous and grant each of these executives two support staff. Suppose next that President Bush asked this group of executives, "I would like you to emerge at the end of this week with a viable strategy for health care for America, a strategy that you would either support, or at least not sabotage."

I would predict that these executives would emerge, after a week, without any concrete plan, without any coherent strategy. Instead, they would emerge with the following three platitudes: First, everyone in America should have access to health care, regardless of ability to pay. Second, health care costs in America are too high. Third, we do not like Government regulation in health care or anywhere else.

That's what these executives would be likely to come out with. And therein lies the main problem of American health care. It is the intellectual bankruptcy of the business community—and I say that with all due respect to the colleagues on my left—it is the intellectual bankruptcy of the American business community in regard to health policy that has plagued this country's health

policy for some 20 years and, I predict, that will plague it for at least another half decade.

But in the latter part of the 1990's, I do believe forces will ultimately push straight thinking on that side of the health care sector as well. By that time America's business leaders may find themselves so frustrated by their inability to control their health spending that they will ditch their rigid ideology in favor of a pragmatic compromise. Let us all hope that day will come sooner rather than later.

Thank you very much.

[The prepared statement of Mr. Reinhardt, together with the attachments referred to for the record, follows:]

PREPARED STATEMENT OF UWE E. REINHARDT

DOES SPENDING BY AMERICAN BUSINESS ON HEALTH CARE FOR EMPLOYEES ERODE THIS NATION'S COMPETITIVE POSITION?

Statement by

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Presented to

THE JOINT ECONOMIC COMMITTEE OF THE

CONGRESS OF THE UNITED STATES

Washington, D.C.

May 23, 1990

My name is Uwe E. Reinhardt. I am the James Madison Professor of Political Economy at Princeton University, Princeton, New Jersey. Much of my research in the past two decades has focused on health economics and health policy.

I thank you, Mr. Chairman, for the opportunity to appear before your Committee and to comment on the widely held thesis that spending on health care in the United States threatens to erode the competitive position of American industry in the world market.

As you and your Committee's staff may know, my views in this issue have been set forth at length in two recent publications in *Health Affairs* (Winter 1989 and Spring 1990). 1I would like to request that these two publications be included in the record of this hearing. In this statement, I shall merely summarize the points made in these two papers, after presenting a few statistics on the nature of health spending in the United States.

A. PAST AND PROSPECTIVE TRENDS IN HEALTH-CARE SPENDING

According to the latest data just published by the Health Care Financing Administration of the Department of Health and Human Services, total national health spending in the United States reached $ 539.9 billion, or 11.1% of a Gross National Product (GNP) of $ 4.881 trillion. The comparable figures for 1980 were $ 249.1 billion health spending out of a total GNP of 2.732 trillion, or 9.1% of that year's GNP.

In terms of effective compound growth rates, health spending during 1980-88 increased at an average annual rate of 10.15%, while GNP grew at an annual average compound rate of only 7.52%. If this differential in growth rates were to persist throughout the 1990s, then roughly between 14% and 15% of the GNP would be spent on health care in the year 2000 and close to 20% by the year 2020. Most observers of the American health system believe that the forecast for the year 2000 is close on target.

As the newspaper clipping excerpted in Figure 1 overleaf illustrates, no other industrial nation currently spends as high a percentage of its GNP on health care as does the United States, and no other industrial nation is likely to spend anywhere near as a high a proportion of its GNP on health care in the year 2000 as will the United States. An explanation of these differences in spending across nations is offered in yet another paper I would like to submit for the record. This paper is entitled: "Providing Access to health Care and Controlling Costs: Approaches abroad, Options for the United States."

[Figure 1]

Figure 2 below depicts the *primary sources* of health-care financing in the United States over the period 1980-88. The *primary source* of this financing must be distinguished from the *ultimate incidence* of health-care costs. The *primary source* may be an institution--for example, an insurance company, a business firm or a government--which pays the

FIGURE 1

Anatole Kaletsky on US employers' change of attitude to health insurance

Why every Chrysler has a $700 health bill

"I NEVER thought I would sit in favour of a government health policy but there are things the government must do. We have to spread the burden."

If Mr Robert Mercer, the former chairman of Goodyear Tire, had made this remark 10 years ago, his fellow industrialists would probably have concluded that he himself was in need of a real cure. The "socialised" health services of Britain and Canada had always figured prominently in the political demonology of the US business community. It was simply unthinkable for businessmen to call for greater government involvement in what was, after all, the country's biggest industry.

In the last few years, however, the rising cost of medicine has turned into a critical issue for many American businesses. According to the Bureau of Labour Statistics, approximately 80 per cent of full-time workers in companies with more than 100 employees are covered by corporate health insurance plans. Private employers pay for about a quarter of the country's $600bn in medical costs. In the last two decades, provision of medical insurance has steadily extended from Fortune 500 companies to relatively small employers, so that a survey of 9,000 small companies conducted in January by the National Association of Manufacturers found businessmen citing health costs more than any other issue as the greatest threat to their economic vitality and ability to compete."

It is largely because of health benefits that US labour costs are rising at an uncomfortable 6 per cent annually, despite moderate pay settlements that have kept the growth of average earnings to only 4 per cent. Yet while businessmen obviously prefer a private system, talk of "national approaches" to medicine is becoming commonplace in boardrooms from Detroit and Akron to Hollywood and even Wall Street.

The latest reminder of the corporate medical crisis was a strike against four of the seven regional telephone companies which at its peak in mid-August involved 200,000 employees. The dispute held the rapt attention of the business community because health, rather than pay, has been the main issue.

The Bell telephone system had long prided itself on providing its employees with the best medical package in American business. But with average health insurance premiums rising by 10 to 15 per cent a year over the last decade, the telephone companies decided that they had had enough. In June, AT&T tried to force its employees to pick up part of its $10bn annual medical bill by paying 20 per cent of their health costs up to a limit of $1,000 a year. The company withdrew in the face of a strike threat, but achieved an unexpectedly modest pay settlement in exchange.

Last month, some of the Baby Bells went where their erstwhile parent feared to tread. Nynex, the company which serves New York and New England, decided to make health costs the central issue in its collective bargaining. Even with the concessions it was seeking, Nynex said that its medical bills would grow by 68 per cent to $5,800 per employee over the next three years. The unions, however, have been equally immovable. Defence of medical benefits has proved far more effective in rallying the members than demands for higher pay.

The US now spends almost 12 per cent of its GNP on health, up from 8.1 per cent in 1981. This represents a crushing burden on the economy in absolute terms; the sum is equal to the nation's spending on education and defence combined. It also puts American businesses, which pay about 38 per cent of the nation's medical bills, at a huge disadvantage against foreign competitors. Canada spends only 8.6 per cent of its GNP on health. The figures for Europe and Japan are even lower.

Chrysler has pointed out that for every vehicle it builds in the US, it spends $700 on employee health care. The comparable figures for car manufacturers in Canada and Japan are $223 and $161, the company estimates. Worse, Chrysler's workforce has shrunk markedly in recent years, while the number of retired workers protected by its health schemes continues to rise. As a result, the company's health costs amount to almost $6,000 for every worker it employs. Meanwhile, Chrysler's Japanese competitors are able to start new plants in the US employing only young workers and carrying no burdens for past generations of retirees. So the cost of health care hobbles the company with a big and growing competitive disadvantage even against Japanese plants on US soil.

Not surprisingly, Chrysler's outspoken chairman, Mr Lee Iacocca, has been America's most vocal critic of the present system of medical financing, going so far as to suggest a Canadian-style system of nationalised health insurance.

Less flamboyant business leaders have also moved albeit cautiously in this direction. Ford is currently conducting an extensive study of business attitudes to health care in preparation for a major statement on the subject. The basic thrust of its approach is already clear. The country needs "a national strategy," because the problem of private medical costs "is larger than any one company." A senior Ford executive says Bethlehem Steel had actually committed itself to lobbying for a "national health policy" in its recently negotiated employment contract with the United Steelworkers.

Other companies, including American Airlines and Baxter International, have gone further, backing a seemingly revolutionary bill drafted two years ago by Senator Edward Kennedy. The bill would require all employers to provide health insurance to their full-time employees.

A few years ago, the idea might have been greeted with alarm. Today, the Kennedy bill enjoys "quite a lot of support," according to Ms Sharon Connor of the National Association of Manufacturers (NAM).

Lee Iacocca has gone so far as to suggest a Canadian-style system of nationalised health insurance

The interest in some kind of legislation stems partly from sheer exasperation. "We simply won't be able to avoid discussion of a national health insurance system in the next few years," says Mr Warren Billings, head of employee benefits at AT&T, although he personally deprecates the idea. "We could get national insurance out of frustration. Employers backed by directors have tried everything to get a handle on the cost problem. Some of us are finally throwing up our hands and saying let the government do the job. I'm not, but give me another year or so."

According to Ms Connor, there are better reasons for why corporate America is looking at national approaches to health. One is that companies end up footing the bill for millions of Americans who fall through the cracks of the US health system. About 37m people are covered neither by private health insurance nor the government-funded Medicare and Medicaid programmes, which cater for the elderly and the very poor. Few are ultimately denied treatment in emergencies. Instead, the costs of treating them are added to the hospitals' overheads and passed on to private patients and their insurers. Last year, the hospital industry's total "uncompensated care costs" came to about $60bn. This may have added up to 10 per cent to employers' hospital bills.

An even bigger financial problem for private employers has been the Federal government's attempts to control its own Medicare and Medicaid costs, which account for 40 per cent of US health spending. Government payments for numerous routine procedures have been reduced sharply since 1981 by classifying treatments into "Diagnostic Review Groups," each of which is subject to a cash limit. But instead of cutting their expenses in line with lower government payments, hospitals have gradually made good the shortfalls by raising their charges to patients who are privately insured. A recent HIAM survey found that its members' insurance costs had risen by 26 per cent last year, partly because of this by-product of government austerity.

According to Dr Wendy Gray, a researcher at the Conference Board, another big business organisation, the Medicare-Medicaid problems have been just one example of an exasperating general law of medical inflation. "It is like squeezing a balloon, each time you clamp down on one trouble spot another bulges out of control."

She cites another example of this principle. When many insurance companies started requiring second opinions before approving surgery, their costs increased because most second opinions were confirming "Physicians rely heavily on their colleagues for referrals," Dr Gray notes.

There seems to be a fundamental problem at the root of all these disappointments. "The trouble is that American medicine is based on a tradition of professional entrepreneurship, not public service," Professor Alain Enthoven of Stanford Business Schools wrote recently in a widely discussed article in the New York Times.

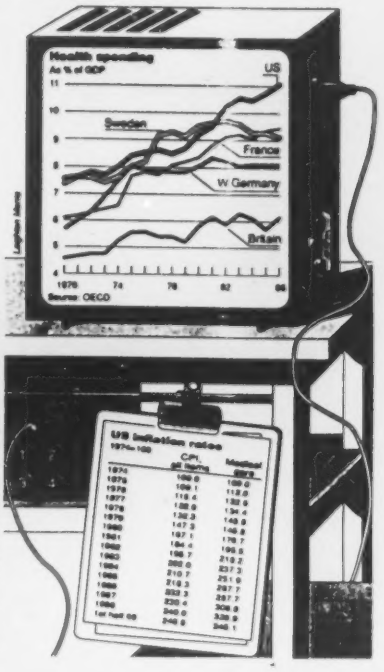
When medicine is a business, treatments are paid as if they were consumer products and hospitals actually stimulate demand for care. Many health experts in the business community conclude that long-term cost reduction may depend on innovations which restrict consumer choice and limit or redirect medical marketing. Three such reforms are widely discussed: shifting the remuneration structure towards preventive medicine, consolidating specialised treatments and costly diagnostic facilities in "centres of excellence" and channelling patients through employer or insurance-sponsored Health Maintenance Organisations (HMOs) or "Preferred Provider Organisations."

Unfortunately, reforms of this kind are difficult for individual employers or insurers to undertake on their own. Preventive medicine produces benefits only in the very long-term and often looks like a waste of money for individual employers or even insurance or expansion with mobile workforces and client groups. Centres of excellence are politically unpopular because they demote many smaller community hospitals.

HMOs smack of the British national health system by limiting the patient's choice of doctors and using general practitioners as "gatekeepers" to restrict access to hospitals, specialists and expensive hi-tech treatments. They have been unpopular with unions and employees and have disappointed many of their sponsors with the meagre savings produced. In the context of US medicine, patients subject to HMO restrictions often conclude that they are second-class citizens receiving sub-standard care. This can defeat the purpose of medical insurance, which corporations offer to win their employees' loyalty and raise their morale.

Dr Gray says: "The largest companies have historically prided themselves on providing the best of health benefits to their employees. Many are facing shortages of skilled workers and want to remain competitive at the top of end of the labour market. It is just not politically feasible for them and their insurance companies to take the lead in restricting medical delivery and costs. One way or another the government may have to get more involved."

Additional research by Rivka Nachmias.



provider of health care. Ultimately, however, these institutions do not bear the economic sacrifice required by spending on health care. That sacrifice is always borne by the human beings to whom these institutions necessarily pass the cost of their spending on health care: either their clients, or their employees, or their owners. Just who the proverbial donkey is on whom the final tab sticks depends primarily on the agility of these donkeys' proverbial posteriors, that is, on their ability to evade attempts to stick the health-care tab on them. I shall return to that point later on.

[Figure 2]

The spending figure underlying that Figure 2 is defined as "health services and supplies," a statistic that excludes research and construction. That figure amounted to $520.5 billion, or 96% of "total national health spending," a statistic that includes research and construction in 1988.

As Figure 2 illustrates, roughly 21% of total spending on health services and supplies in 1988 was financed by patients themselves, directly at the point of receiving these services and supplies. That percentage has declined somewhat since 1980, in spite of efforts by both government and business to shift a larger percentage of health-care costs back to the patient through higher deductibles and coinsurance rates.

Private health insurance covered about 33% of total national outlays on health services and supplies in 1988, up slightly from the 30% or so financed in this way in 1980. The great bulk of these expenditures were, of course, financed by American business firms in the form of employer-provided health insurance policies for employees.

Governments at all levels financed about 42% of all spending on health services and supplies in 1988. That percentage has held steady throughout the 1980s, although it has dipped ever so slightly in recent years.

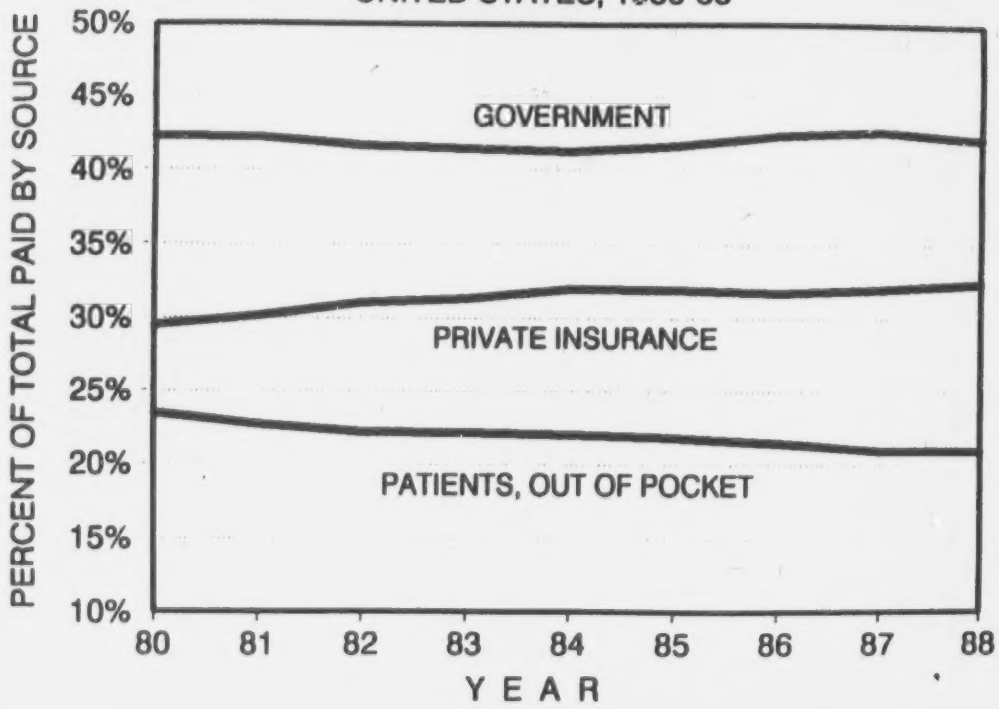
Philanthropy and other private sources covered the remaining 3% of total national outlays on health services and supplies in 1988. That remainder has been trivial throughout the 1980s.

The forces driving increased health spending by business are, for the most part, the same forces that drive health-spending by all primary payers in this country: it is a compound of interacting factors that includes (a) the ever more sophisticated and expensive technical innovations introduced into health care by our entrepreneurial health sector, (b) the search for income by our ever growing corps of health-care entrepreneurs and professionals, (c) the demand for high-tech medical intervention by a relatively squeamish population that stands out in the world for its aversion to risk in the diagnosis and treatment of illness and (d) a tort system that drives even conservative providers of health-care into high-cost medicine that leaves no stone unturned.

FIGURE 2

SOURCES OF HEALTH-CARE FINANCING

UNITED STATES, 1980-88



SOURCE: HEALTH CARE FINANCING ADMINSITRATION, MAY 1990.

But business appears also to be the a recipient in a game that might be called *the economics of the hot [health care] potato*. In the American health system, money flows from the rest of society to the providers of health care through a myriad of money-pipes, each controlled by a distinct payer. In many instances, a given medical treatment administered by a given provider to a given patient may trigger money flows to this provider through three or more distinct money pipes (e.g., Medicare, Medicaid, one or more private Medigap policies and the patient's own purse). The game in this multiple-pipe system is for one payer to use market muscle to pass on health-care costs to other payers. This phenomenon, generally known as *cost shifting*, is illustrated in Figure 3.

[Figure 3]

Figure 3 illustrates a hypothetical hospital with an average total cost per average inpatient day as shown in the diagram. Both Medicare and Medicare are assumed to pay less than fully-allocated costs to this hospital, although more than true incremental cost (i.e., costs excluding allocation of fixed overhead). This assumption is fairly realistic for the bulk of American hospitals today. A hospital with excess capacity will, of course, find it profitable, *in the short run*, to accept Medicaid and Medicare patients, as long as reimbursement exceeds incremental costs, even if, *in the long run*, these patients do not cover their share of the hospital's fixed overhead. Uninsured patients, on the other hand, often do not even cover incremental costs. If they are treated by the hospital, the latter does so out of a self-imposed sense of charitable obligation, or for reasons of image.

Who, then, does cover that part of the hospital's overhead not covered by the public payers and the uninsured? Traditionally this has been the privately-insured patient, as is illustrated in Figure 3. Depending on their power in a particular hospital market, large business firms may be able to resist this cost shift to some extent through negotiated discounts off full charges. Alas, small business firms typically lack this market clout. They end up covering whatever overhead and profit is not generated from Medicaid, Medicare, the uninsured and big business.

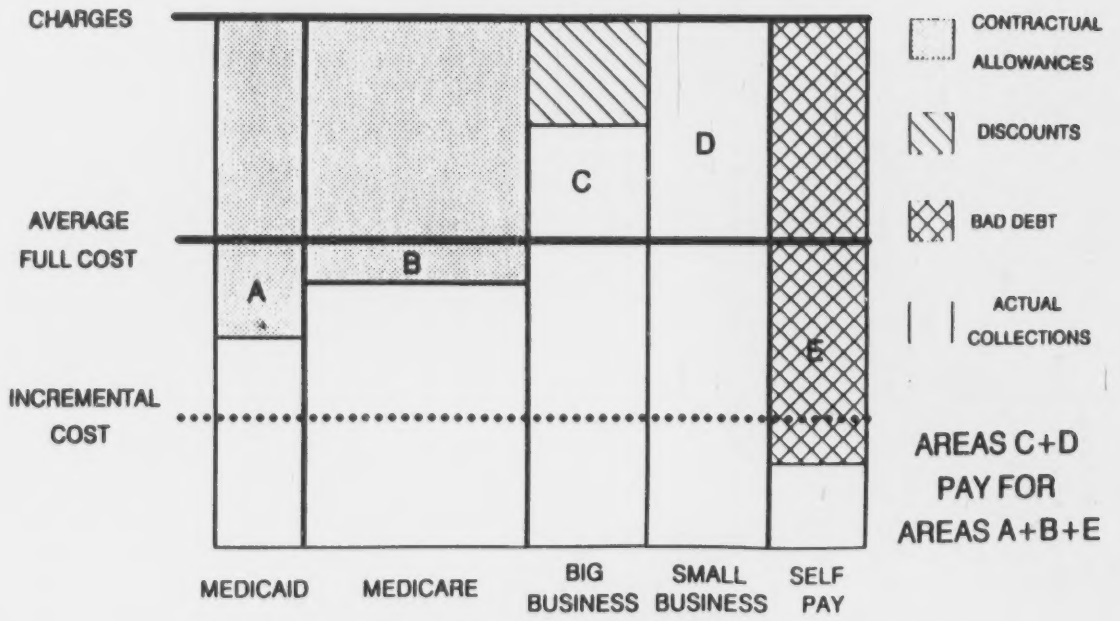
In effect, cost shifting of this sort has become this nation's way of raising taxes without having our politicians' lips trace out that much-loathed word "taxes." Although the business community may loathe the cost-shift as well, it actually is the only viable option left to a Congress charged with *lowering* or at least not raising taxes, reducing the deficit in the Federal budget and, at the same time, providing the aged and the poor with access to needed health services. What else did the business community and the public expect?

It may be noted in passing that no other industrialized country now uses this method, for no other country views it as self-evident that payers with the least degree of market power in health care properly ought to make the highest contribution to the health sector's overhead and profits. It is a uniquely American approach to health-care financing. As I argue in my paper "Providing Access to Health-Care and Controlling Costs," however, it is my sense that the arrangement will not survive much longer in the United States either. In the end, small business in this country is likely to tire of being the recipient of the hot

FIGURE 3

HOSPITAL CHARGES, FULL COSTS, INCREMENTAL COSTS AND COLLECTIONS (PER AVERAGE DAY)

(FOR A HYPOTHETICAL AMERICAN HOSPITAL)



SOURCE: Adapted from Lewin/ICF, Inc.

potato in health care. We can expect its representatives soon to appear before Congress seeking remedial legislation. In the end we probably shall wind up with a comprehensive *all-payer system* somewhat akin to West Germany's health-insurance system, but only after long and bitter debate and only after truly torturous, piece-meal health policy. Under an *all-payer* system, all payers in a market area would pay the same provider the same fees for the same procedure. Large, powerful payers could not achieve a price advantage over small payers under such an arrangement, nor would government pay less than private payers[1]. The fees would, of course, have to be negotiated between area-wide associations of payers and providers.

But in the meantime American business is likely to be saddled with a continued, disproportionate escalation in its outlays for health-care. That is, of course, a problem largely of the business community's own making, for that community has been largely responsible for structuring the current health-insurance system in this country, for structuring the income-tax preferences that sustain the system, and for kindling among employed Americans an entitlement mentality in health care so exaggerated that it would not be countenanced even in their wildest dreams among publicly financed American patients, or among patients elsewhere in the world.

In fact, today, or at another time, I would be happy to defend the proposition that most of the financial problems currently besetting the American health system have their origins in the rigid ideology and the short-sighted decisions of this nation's business executives.

B. DOES HEALTH SPENDING BY AMERICAN BUSINESS FIRMS IMPAIR THESE FIRMS' ABILITY TO COMPETE IN THE INTERNATIONAL MARKET PLACE?

I would now like to return, Mr. Chairman, to the question posed in your invitation to appear before this Committee, namely, *Does spending by American business on health-care for employees impair these firm's competitiveness in their product markets*? If so, Congress might feel moved to assist the business sector, even if the troubles faced by business in health care were mainly of the business sector's own making.

To approach this question, it is best to decompose it into several parts that are frequently intermingled in the discussion on this question and therefore confuse the debate, to wit:

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[1] Hospitals in the State of New Jersey have been paid under such an all-payer system for some time.

1. **Is the American health system wasteful in the sense that some of the productive resources it uses would create greater well-being among the American people if these resources were deployed in other sectors of the economy?**

2. **If the answer to the first question is "Yes," is it the allegedly low benefit-cost ratio in American health care that impairs the competitiveness of American business, that is, would there be no problem if every dollar business spends on health care were perfectly defensible in terms of the benefits it yields in terms of health status?**

3. **Even if the answer to the first question were "No," that is, even if the American health sector were perfectly efficient, could health-care spending by American business nevertheless be said to impair business' international competitiveness?**

4. **If the answer to both the first and the third questions were "No," would that eliminate all legitimate objections to legislation that would mandate all American business firms--large and small--to provide their employees with health-insurance coverage?**

American business executives linking health-care costs to their ability to compete commonly pepper their remarks with allusions to the "enormous waste" in the American health system. To buttress their case, they can cite numerous recent studies suggesting that anywhere between 15 to 30 percent of major surgical operations performed in the United States are unnecessary.[2] In other words, few business executives and few students of American health care doubt any more that the answer to the first question is "Yes."

Such waste, of course, would pour salt into whatever wounds health-care costs are said to inflict upon American business. But the removal of that salt would still leave the wounds. Even with perfect economic efficiency in American health care, the health-insurance premiums paid by American business firms for their employees would still be large as a percentage of total payroll expense and net profits. The alleged burden of health spending would be lessened somewhat, but it would not go away. Thus, the proper answer to the second question raised above is "No." The alleged waste *per se* is not the chief culprit behind the problem lamented by business executives.

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[2] For an excellent, easily readable summary of such studies, see Robert H. Brook, M.D., Sc.D. and Mary E. Vania, Ph.D., *Appropriateness of Care: A Chart Book*, Washington, D.C.: National Health Policy Forum, George Washington University, June 1989.

Which leads us to the third question raised above, namely, do the health insurance premiums American business firms *voluntarily* pay on behalf of their employees impair these firms' ability to compete in the international market place? Here the emphasis is on the word *voluntarily*, because that is crucial to the argument I make in my two papers published in *Health Affairs*. This argument goes as follows:

> **Business competes for labor in a market whose clearing price is total compensation, including fringe benefits. In a well-functioning labor market, the fringe benefits and cash take-home pay act as substitutes for one another. If business and labor negotiate overtly or implicitly to put more of that total compensation into fringe benefits, then commensurately less of that compensation will be paid out in cash. There is no reason, however, why such a decision should necessarily reflect itself in the price of the firm's products, unless management decided to give that a try, come what may.**
>
> **Given the overall level of total compensation, its decomposition into various fringe benefits and cash wages in a particular industry reflects largely the relative market power enjoyed by management and employees, the preferences of employees who chose to work in that industry and, of course, also the tax laws which tend to shield many fringe benefits from taxation while exposing cash income to full marginal tax rates.**

It may be argued, of course, that a business firm *will* typically seek to pass the rising cost of its health-insurance program forward to its customers in the form of higher prices. If foreign competitors in the international market are not burdened by such cost-increases, so goes the argument, then they gain a competitive advantage over American firms. But the culprit in this case is not health-care spending as such, but a poor managerial response to such cost increases.

First, it would be foolish to raise product prices in such a situation for any reason, and any management seeking to do that would not be worth its pay. Second, its is management's function to procure labor for the firm in a manner that does not threaten the survival of the firm. Part of that mandate in the assumed situation would be the task of persuading labor convincingly that added fringe benefits--or increases in the cost of existing fringe benefits--must necessarily come at the expense of cash take-home pay and that, perhaps, a realignment of fringes and cash wages may be in order, depending upon labor's preferences. Politically, of course, that act of persuasion will be the more difficult, the more blatantly top management permits its friends on the Board to bestow upon management high compensation, fringes and perks, as has been management's wont in American business throughout the past decade. In any event, failure to negotiate with labor an economically viable level of total compensation could not be fairly blamed on health

care. It is a managerial failure, pure and simple, and one of which many American business firms can be justly accused.

In short, then, my answer to the third question raised above is "No," the rising cost of health insurance coverage paid for by American business does not by itself make American business non-competitive in the international market place. But if that were really so, what of the fourth question raised above? Does it then follow that *mandating* upon all American business firms employer-paid health insurance coverage for all employees is not harmful to the economy?

Here we must come back to the crucial distinction between *voluntarily* provided insurance coverage and *mandated* coverage.

Presumably, where health-insurance coverage is *voluntarily* provided in an industry, that policy reflects direct or implicit negotiations between management and labor. As already noted, the outcome of such negotiations reflects the relative market power of both sides to the bargain, the tastes and preferences of employees, and the treatment of fringe-benefit income and cash income by the tax code. Workers in industries with relatively low market-clearing levels of total compensation are likely to prefer cash income to certain fringes, because their dire economic circumstances put cash income at a premium. Probably for that reason, millions of full-time workers working for small business firms at low-income compensation do not now have any health-insurance coverage at the work place. An added reason surely is that this nation's health-insurance industry has never been able to offer small business firms health-insurance products on the same terms and at the same premiums enjoyed by large business firms. The private health-insurance industry has substantially failed to service that segment of our economy.

A mandate on small business firms who do not now offer their employees health-insurance to provide such coverage amounts to a head-tax upon employment, because the premiums paid for that purpose are independent of workers' wages. Such a head tax (about $2,000 to $ 3,500 per employee at this time) might represent a substantial percentage increase in total compensation for low-paid workers *if cash take-home pay could not be reduced substantially*. Unless such employers could pass forward the cost of health-insurance coverage in the form of higher prices for their products, they would pass them backward in the form of lower cash wages to their already low-paid employees.

At best, a backward shift of the head-tax implied by mandated employer-paid health insurance would thus be tantamount to imposing the head-tax directly upon the worker. Unlike most other taxes, of course, this tax would bestow upon the worker a direct benefit--insurance coverage. But the worker might actually have preferred added cash income to that coverage, relying upon the available patchwork of charitable care as insurance of last resort. Indeed, it is conceivable that the head-tax, if passed backward to the employee, would depress cash take-home pay to such an extent that the worker would prefer to quit working altogether.

To say, then, that *voluntarily* offered, employer-paid health insurance coverage does not itself impair the competitiveness of American business in the international markets for

its products does not at all imply that *mandated* employer-paid health insurance is therefore a harmless policy--the answer to the fourth question raised above. As I have argued in another paper published in *Health Affairs*[3] and in a summary of that paper published in *The Wall Street Journal* (copy attached hereto), a superior approach might be to mandate health insurance coverage upon the individual and then to make available a tax-financed, publicly administered Fail-Safe health insurance system to all individuals without private health-insurance coverage, at a premium that varies directly with income.

Do any of the preceding arguments excuse American business from vigilant cost control in health care? Not at all. Indeed, there is every reason to believe that through its traditionally lax procurement practices in health care, American business has served needlessly to impoverish its own employees. It will have done so to the extent that its lax, open-ended health-insurance policies have served (1) to facilitate the delivery of medically unnecessary services, or of services with only marginal medical benefit, and (2) to inflate the fees and charges the providers of health care have been able to extract per unit of real health care delivered to patients. In either case, business has effectively traded off their employees' cash income for services whose benefit to the employees did not warrant the sacrifice in cash income.

> **In other words, even if the health-care financed by American business does not necessarily impair its competitive position in the international market place because these costs can be shifted backward to employees, business has every moral and economic reason to act as a prudent purchaser of health-insurance and of health-care on behalf of its employees.**

One looks forward to the day when business will seriously begin to own up to this obligation, as it has not so far.

C. DOES HEALTH-SPENDING IN AMERICA IMPAIR COMPETITIVENESS BECAUSE IT DISPLACES INVESTMENTS IN PRODUCTIVE CAPITAL?

It is sometimes suggested that health-spending impairs the ability of America to compete in the international market, because health-care is *consumption*, as such displaces public and private investment in productive capital, and thereby lowers the average productivity of American workers. Figure 4 illustrates the macro-economic imagery underlying this line of reasoning.

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[3] Uwe E. Reinhardt, "Health Insurance for the Nation's Poor," *Health Affairs*, Spring, 1987; pp. 101-12.

[Figure 4]

The nation's GNP represents all of the valuable goods and services produced by a nation in a given year and traded in the market place[4]. Some of these goods and services are devoted to providing pleasure and well being in the same year. We label that output *consumption*. Other goods and services support the formation of productive capital (including *human capital*, otherwise known as education) that will provide enhanced future consumption streams. We label that part of output *investment*. Clearly, spending on health care may be either *pure consumption* or *pure investment* or, more typically, a mixture of both. That is why health spending is shown as a distinct slice in Figure 4.

To the argument that added health spending cuts directly into investment one can respond as follows.

First, as, noted, spending on health care itself may be essentially an investment. This appears to be particularly true of preventive care directed at young persons--for example, prenatal care for pregnant teenagers.

Second, even if health care did take the form purely of consumption, it is not clear that it comes at the expense of investment. For all we know, it displaces primarily other forms of consumption.

Third, even if consumption-like health spending did displace investment, so does any other form of consumption in our economy and, indeed, so do investments yielding only marginally positive or even negative benefits. In connection with the latter, one cannot help but think of the perfectly predictable, vast misallocation of resources into shoddy projects facilitated by the Congress through its dubious policy of *deregulation* of the investment side of the Savings and Loan Industry, coupled with *government insurance* of the liability side of that industry's ledger. The funding for this mistake alone could amply have financed a comprehensive child health-care program in this country for several decades.

Once again, the preceding arguments are not at all meant to excuse those who receive health care and those who pay for it--the government included--from constant vigilance over the benefit-cost ratio associated with added spending on health care. *There is never any excuse for sustaining benefit-cost ratios below one in any sector of the economy.*

On the other hand, these arguments *are* meant to suggest that spending on visibly beneficial health-care ought not to be curtailed simply because such spending is thought to displace *investment* in productive capital. There are just too many other inviting targets for a reallocation of resources toward *investment*, as this Congress knows only too well.

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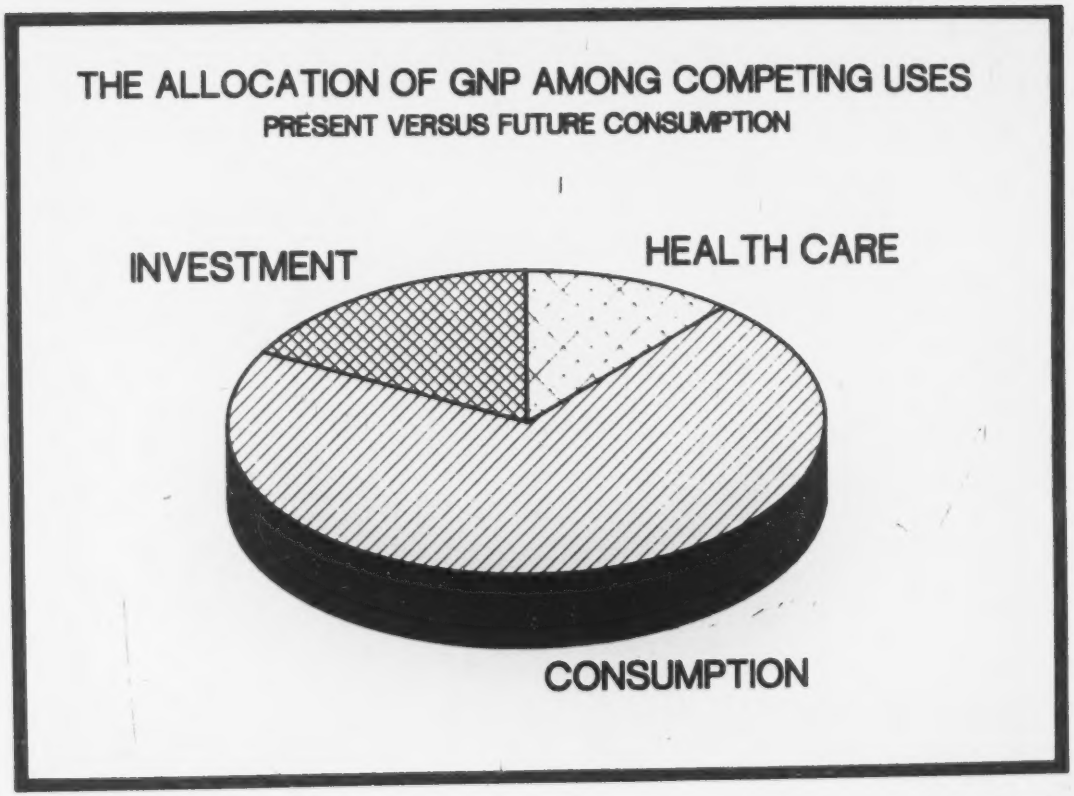
[4] Sadly, and most harmfully for national policy, that measure of national achievement eclipses from view the crucially important non-market services produced in private homes, notably the arduous labor of child rearing.

FIGURE 4


THE ALLOCATION OF GNP AMONG COMPETING USES
PRESENT VERSUS FUTURE CONSUMPTION
INVESTMENT
HEALTH CARE
CONSUMPTION

THE WALL STREET JOURNAL WEDNESDAY, JANUARY 11, 1989

Toward a Fail-Safe Health-Insurance System

By Uwe E. Reinhardt

Critically ill Americans used to be able to get the care they needed from a nearby hospital, even if they could not pay the bill. The hospital would pass on the cost to private health-insurance carriers who, in turn, would pass it on to business through the premiums for employer-paid group health insurance.

This hidden tax system is now coming apart under the forces of a growing number of the uninsured (now an estimated 37 million), of the ever increasing cost of our ever more sophisticated health care, of the business community's attempts to rein in its health-insurance premiums, and of the public sector's increasingly desperate attempts to control its outlays on Medicare and Medicaid.

Caught at the confluence of these forces, hospitals have begun to deny access even to critically ill patients. Some have even closed their emergency or neonatal-care units, because these are the main points of entry of indigent patients. According to surveys conducted by the Robert Wood Johnson Foundation in 1982 and in 1986, more than one million Americans ineligible for Medicaid are now being denied access to needed health care in any given year for inability to pay.

Political Appeal

Like it or not, the nation will soon be called upon to confront this issue, and replace the crumbling, hidden tax system with another one. Mandating all employers to provide employees health insurance is one option. It would be a payroll tax by another name. A better alternative might be a modified Medicaid system financed explicitly by a combination of income and excise taxes.

Mandating employer-provided health insurance has enormous political appeal, as politicians could coerce fiscal transfers within the private sector without having to account for them through the government's budget. They could pursue desired social goals without letting their lips spell the word "taxes"—no small advantage.

Given this advantage, it is not surprising that mandated benefits enjoy wide support among Americans of all political stripes. The idea first surfaced in President Nixon's Health Message to the Congress of Feb. 18, 1971, and in his subsequent legislative proposal, the Community Health Insurance Partnership. That proposal was shelved as inadequate by Sen. Edward Kennedy and then-Rep. Wilbur Mills. But it has resurfaced during the 1980s, pushed by such leading Democrats as Reps. Pete Stark and Henry Waxman, Massachusetts Gov. Michael Dukakis—and Sen. Kennedy.

Several executives of large U.S. corporations—among them Robert Crandall of American Airlines and Karl Bays of IC Industries (now Whitman Corp.)—also have supported employer-mandated benefits in recent testimony before Congress. This is not surprising, since almost all of the cost of health care rendered the indigent gets passed along to big business. Mandated health insurance would shift that cost onto the payroll accounts of the firms that employ so many of the uninsured, some of which are the large firms' competitors.

One should not, however, overlook a major shortcoming of mandated employer-paid benefits: They are payroll taxes in disguise, with all of the pernicious economic consequences of such taxes.

Since the vast majority of uninsured workers are in low-paying jobs at small firms, mandated employer-provided health insurance will mean a major percentage increase in these small firms' payroll expenses. Unless they can pass on the added tax through higher prices—which is not to be taken for granted—they are apt to shift much of it back to employees in the form of unemployment or lower wages. If so, employer-mandated health insurance will end up hurting the very people it is intended to help.

A better alternative would be to mandate that coverage upon the individual himself, and then to make sure that affordable health-insurance policies are available to all Americans. As a society, we are bound by the oft-professed pledge not to let a fellow citizen die because he can't afford health care. That noble sentiment can, of course, be exploited by would-be free riders among, say, the 29% of the uninsured who reported family incomes in excess of $30,000 in 1986.

One way to preclude exploitation by free riders might be to fold every American without insurance into a basic, catastrophic Fail-Safe insurance program for which its participants would be charged a progressively rising income tax. People with adequate private insurance coverage would be excused from that tax, as would people below the poverty line.

To control the cost of this program, its benefits should be delivered through qualified managed-care systems, such as preferred provider organizations or health maintenance organizations, under competitively bid contracts with the Fail-Safe system. Further cost control might be achieved by imposing some cost-sharing by patients above the poverty line, up to a maximum out-of-pocket exposure that would vary with income.

The Fail-Safe system could be administered through the state governments, as is the current Medicaid program. Because there is such a high variance in the economic fortunes of individual states, however, the basic benefit package should be defined at the federal level and should be supported through federal cost-sharing, partially with the tax premium collected for that purpose.

A better alternative would be to mandate coverage upon the individual himself, and then to make sure that affordable policies are available to all Americans.

If that tax were made sufficiently progressive, most Americans could be induced to seek cheaper or more comprehensive coverage in the private sector, typically by prevailing upon employers to make such coverage available. Because this nation faces a growing labor shortage, most companies probably would find it in their interest to do so. That circumstance would also most likely prevent many firms now offering group insurance coverage from dumping their employees into the leaner Fail-Safe system.

In 1986, the relatively comprehensive Medicaid program spent an average of $708 per child and about $1,180 per adult in the program. In that year, established HMOs charged annual premiums of $856 for individuals and $2,569 for families. (Those premiums would now be closer to $1,160 and $3,200, respectively.) Most of the 37 million currently uninsured are relatively young; about one-third are children. Had all of them been in the proposed Fail-Safe system in 1986, their total health expenditures might have been somewhere around $40 billion. Of course, the 29% with family incomes in excess of $30,000 would probably be driven into the private sector, so that total program costs might be closer to $30 billion.

Available estimates suggest that somewhere between $8 billion and $12 billion of this total would be from increased demand caused by extending coverage to the now uninsured. The remainder was already spent somehow in 1986, by the uninsured themselves and by other payers, mainly business, to whom the cost of charity care had been shifted.

Financing for the Fail-Safe system would come from a variety of sources. First, the system would collect income taxes from the non-poor it covers. The non-poor would also contribute funds through cost-sharing at point of service. Because the bulk of the non-poor in the Fail-Safe System would have very low incomes, however, it is doubtful that more than $5 billion to $10 billion could be raised from them, depending upon their number. The remainder of the funds would have to be raised through a combination of excise taxes and income taxes, which should come as no surprise. After all, mandated employer benefits, too, would represent additional taxes. Someone has to pay the providers of care to low-income American families if we want those families to have access to at least a basic level of care.

Alcohol, Tobacco and Gasoline

Potential targets for an excise tax would be products that have a deleterious effect on health—among them alcohol, tobacco and gasoline, whose use contributes to ill health through pollution and highway accidents. Finally, all Americans might be asked to bear a small surcharge on their income tax, specifically earmarked for indigent care.

The Fail-Safe system would have several major advantages. First, it would keep the cost of health insurance out of the payroll expense accounts of firms that simply cannot afford it. Second, it would lift the burden of uncompensated care from the shoulders of health-care providers, a burden for which they do not bear responsibility. Finally, in that it is paid for by specific taxes, it would make more explicit the cost of being one's poor brethren's keeper, which ought to be a good idea in a well-functioning democracy.

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HEALTH CARE SPENDING AND AMERICAN COMPETITIVENESS

by Uwe E. Reinhardt

Prologue: *American business plays a curious role in the health policy-making activities of the United States. Its degree of involvement falls well short of the magnitude of its massive commitment to financing the medical care of its employees. The reasons for its limited involvement are multiple. Corporate chieftains have been slow to engage the complex issues of health financing because such issues are usually not central to their businesses. They prefer to wield the limited influence any individual or institution can bring to bear on public policy making on matters that seemingly affect their respective bottom lines more directly. Beyond this point, American corporations have been ambivalent about promoting a more pervasive role for government in health financing and delivery because of their general philosophical distaste for regulation. In recent years, though, one argument has resonated with chief executive officers who have been exhorted by their employee benefits managers to become more heavily involved in health policy making—the notion that America's soaring medical bill is making corporations less competitive in world markets. In this paper, Uwe Reinhardt of Princeton University challenges this argument, asserting that it is unlikely that high health costs per se render American business noncompetitive at home or abroad. Reinhardt, who was born in Germany, was educated in Canada and the United States, and is now a naturalized U.S. citizen, is a familiar figure in health policy circles. He plays multiple roles: as a policymaker, who employs his international perspective to influence the directions of American policy; as a speaker, who uses humor to educate and inform; and as a writer, who effectively marshals his argument on behalf of whatever case he is striving to build. Reinhardt was a very active participant in the National Leadership Commission on Health Care (see exchange with J. Bruce Johnston in* Health Affairs, *Summer 1989), and has also been an influential voice on the Physician Payment Review Commission.*

Public policy responds to widely shared folklore that is sustained by visible symbols. One such symbol in recent years is the much-cited statistic that an automobile produced in Detroit now contains between $500 and $700 of health care costs, paid for by the auto companies on behalf of their employees. This familiar statistic has nourished the thesis that increases in health care costs have pushed up the retail prices of American automobiles or, conversely, that reductions in this component of manufacturing costs would lead to reductions in these prices.

The belief that increases in health care costs translate themselves directly into higher product prices seems to be a commonplace in the American business community. It supports the argument that employer-paid health care for active and retired employees renders American producers "noncompetitive" in the global marketplace. Thus have health care costs slipped onto the agenda of thinkers who worry about this nation's future place in the world economy.

A second, more circuitous linkage between health spending and "competitiveness" is sometimes made at the macroeconomic level of the economy as a whole. This particular linkage is thought to operate through the negative impact high health spending has on the nation's savings rate and, thus, on its rate of capital formation. Since capital formation is generally thought to enhance labor productivity and the latter influences unit manufacturing costs, one can construct from these linkages a hypothetical relationship from health spending to product prices and thence to "competitiveness." That relationship, incidentally, is thought to touch all our economic activity—even enterprises that do not pay for their employees' health insurance coverage.

At first blush, these beliefs and the arguments they support have considerable intuitive appeal, which may explain their popularity even among observers outside the business community. Further thought on the matter, however, leads me to a set of propositions very much at variance with the prevailing folklore. At the risk of being dismissed as just one more impractical academic "who has never met a payroll," I state these propositions below and defend them in the remainder of this essay.

Three propositions. First, it is unlikely that high health care costs *per se* render American business noncompetitive at home or abroad. Second, it is just as unlikely that the relatively large percentage of the American gross national product (GNP) devoted to health care, by itself, adversely affects the nation's competitiveness. Third, if high health care expenditures do affect this nation's international competitiveness, they are likely to do so through the following combination of circumstances: (1) over 40 percent of health care is now being financed through public budgets; (2) American taxpayers and their political representatives want to keep the

percentage of GNP going through public budgets constant; which means that (3) public funds spent on health care may well come at the expense of our investment in human capital (education) and the nation's infrastructure, both of which are largely publicly financed.

The last factor is likely to be the most important direct link between our high health care expenditures and our competitiveness. One could base on it an economic rationale for shifting health care costs from the public to the private sector, although it is not clear that such a shift is actually feasible. After all, American business may yet decide one day to greet these attempted cost shifts by following Nancy Reagan's famous dictum: "Just say no!"

None of the propositions I offer here should be viewed as a case against vigilant cost controls in health care. They merely are meant to suggest that such controls had best be defended on grounds other than competitiveness. Chief among these other grounds is the question whether, at the margin, additional spending on health care would enhance social welfare as much as would additional spending on other goods and services.

What Is The Price Of Labor?

In a competitive market economy, labor is treated as simply one of many productive factors for which there exists a market-clearing price; that is, the price at which industry's demand for labor just equals the quantity of labor potential workers are willing to supply. According to the theory apparently popular among much of the business community, the market-clearing price in the labor market is the *cash* compensation paid employees. Any fringe benefits laid on top of that *cash* compensation are assumed to come out of the hide of the two other stakeholders in a business firm: its customers and its owners.

If *all* producers competing in the market for a particular product offered workers the same fringe benefits, much of the cost of these benefits might be passed on to customers through higher product prices, particularly if the overall market demand for the product were relatively insensitive to price. If market demand were highly price-sensitive, however, the cost of fringe benefits could not be shifted to the customer so easily, even if all producers offered the same fringe benefits. Buyers of the product would threaten to stop buying if producers sought to raise their prices. Customers could carry out this threat more easily if they could turn to foreign producers blessed with lower production costs and willing to undercut domestic producers. Under these conditions, according to popular theory, the cost of added fringe benefits would have to be borne by the firm's owners in the form of lower profits.

Because financial capital is globally mobile, however, management could expropriate the firm's owners in this way only occasionally and for a short time. In the longer run, a firm can attract equity financing only by offering potential investors the going global rate of return. The growing cost of fringe benefits, according to popular wisdom, therefore puts management between a rock and a hard place: either to price the firm out of its product markets or to destroy the firm's access to the market for equity capital. Either way, according to the theory, the rising cost of health care (and of other fringe benefits) can kill the proverbial goose that lays employees' and shareholders' golden eggs.

A major flaw in this argument is that it completely overlooks the firm's third major category of stakeholders to whom the cost of fringe benefits can be passed, namely, the recipients of these fringe benefits themselves. To be sure, in the very short run, sudden increases in the cost of fringe benefits may act as mere add-ons to a prevailing level of compensation and be at the expense of shareholders. In the longer run, however, the market-clearing price that brings the supply of and demand for labor into equilibrium will be the *total compensation package* paid labor, not just the *cash* compensation. Therefore, in the longer run, the various components into which total compensation can be packaged must be viewed as merely interchangeable. It is not meaningful to single out one particular component of this total compensation package, to divide that component by the number of units of whatever output the firm produces, and then to argue that the amount of this one component per unit of output makes a manufacturer noncompetitive in the product market.

Regional disparities. A factor that might appear to aggravate the problem of health care benefits in the United States is the American practice of tying the health insurance premiums payable by the individual firm strictly to the demographic composition of that firm's own labor force, rather than to the morbidity of a larger community. Under this system of financing, a firm with a relatively older work force will, of course, pay higher average health insurance premiums per employee and unit of product than would a firm with a younger work force, and that may be judged "unfair."

In this connection, for example, auto executives in the Rust Belt typically complain that, quite aside from foreign competition, they cannot compete even with manufacturers located in the southern United States, where competitors' work force tends to be younger and not unionized. Thus, an automobile built in Tennessee is said to contain several hundred dollars less in health care costs than one built in Detroit—which, it is argued, makes automobiles produced in Detroit noncompetitive with similar automobiles produced in Tennessee.

One can offer two observations on this line of reasoning. First, significant cost differentials of this sort would be manifest even if overall national health care costs amounted to only 9 percent of GNP rather than the current 11.5 percent. Reductions in overall national health care spending would have only a small impact on the differential.

More importantly, the argument implies that workers in the Rust Belt cannot be made to understand that, to keep the products they produce competitive with products produced by *American* workers in the Sun Belt, total compensation in the Rust Belt must be competitive with that in the Sun Belt. This implies that cash wages in the Rust Belt may have to be lower than those in the Sun Belt *if Rust Belt workers continue to demand the generous health benefits they have always commanded.* Presumably, an ability to impart this fundamental lesson in economics to employees is part of the managerial competence for which business executives are hired and handsomely paid.

One possible objection to the above may be that many of the Rust Belt industries that are most seriously burdened with employer-paid health care costs do not procure labor in the perfectly competitive labor markets envisaged by textbook theory, but instead procure it from powerful unions, technically known as labor monopolies. From the viewpoint of union members fortunate enough to be employed, the great virtue of a labor monopoly lies in its power to impose upon employers a private minimum-wage floor in excess of the market-clearing level of total compensation. It may be thought that this power enables a labor monopoly to force fringe benefits upon employers as a genuine add-on to cash compensation, rather than as a mere substitute for cash wages. Not so.

If the customers of a unionized firm are highly price-sensitive—that is, if they can readily turn to foreign suppliers of the product—that firm has no more leeway to shift the cost of added fringe benefits forward to customers through higher prices than would a similarly situated firm that procures labor in perfectly competitive labor markets. Nor would the unionized firm find it any easier to shift those costs backward to potential suppliers of equity capital. Instead, in the longer run, a unionized firm faced with a relatively higher compensation level (including fringe benefits) will find it relatively more economical to replace labor with labor-saving equipment. Thus, increases in the cost of the fringe benefits enjoyed by employed union workers would be shifted backward by the firm to newly unemployed union members.

Alternatively, if the union's leaders were sensitive to the plight of potentially unemployed rank and file, they might be cautious in pushing up the total level of compensation too exuberantly and be willing, during wage negotiations, to trade off cash income for fringe benefits, and vice

versa. Recent negotiations in the American labor market suggest a willingness on the part of union leaders to contemplate such trade-offs. To illustrate, in November 1989, the Nynex Corporation (New York's telephone company) settled its long strike with the Communications Workers of America over health care benefits with a package that, according to a Nynex statement, "is approximately $125 million less—or about 25 percent—than the comparable [cash] wage settlements at other former Bell companies."[1] The union had refused to accept direct contributions by employees to their health insurance coverage; evidently, however, it was willing to settle for commensurately lower cash wages.

That union leaders may be a bit ahead of business executives in their study of basic economic principles may be inferred also from a fascinating remark offered by Douglas Fraser, past president of the United Auto Workers union. Responding to an auto executive during a recent debate on American health policy, Fraser observed:

> Before you start weeping for the auto companies and all they pay for medical insurance, let me tell you how the system works. All company bargainers worth their salt keep their eye on the total labor unit cost, and when they pay an admittedly horrendous amount for health care, that's money that can't be spent for higher [cash] wages or higher pensions or other fringe benefits. So we directly, the union and its members, feel the costs of the health care system.[2]

It is certainly true that, if a unionized industry finds it technically difficult to substitute labor-saving devices for labor, a recklessly managed labor monopoly could push the price of labor so high as to help price the industry out of the competitive global product market altogether. The causal factor in this case, however, is not high health care expenditures *per se*, but an overall compensation package that is excessive relative to the compensation paid similarly skilled labor elsewhere.

The Burden Of Postretirement Health Benefits

The preceding analysis applies only to the compensation of active workers. A quite distinct problem arises out of the growing burden of so-called postretirement health benefits.

During the past several decades, many American business firms have taken it upon themselves to operate sizable private social security systems for their employees. They have done so by promising employees health insurance coverage during retirement for costs not covered by the federal Medicare program, on top of defined private pension benefits. Exhibit 1 indicates the prevalence of this type of coverage among retirees age fifty-five and older.

Exhibit 1
Employment-Based Health Insurance Coverage Of Retired Americans, 1987[a]

Age cohort	Percent of cohort with employment-based coverage	
	Policyholder only	Dependent coverage
55 and over	38.8%	9.9%
55–59	50.1	20.6
60–64	51.9	15.0
65–69	40.3	11.1
70–74	37.1	7.6
75 and over	28.1	4.9

Source: A.C. Monheit and C.L. Schur, *National Medical Expenditure Survey—Health Insurance Coverage of Retired Persons*, Research Finding 2, DHHS Pub. no. (PHS) 89-3444 (U.S. Department of Health and Human Services, National Center for Health Services Research and Health Care Technology Assessment, September 1989), 6, Table 2.

[a] A total of twenty-two million Americans age fifty-five or over are estimated to be retired.

Alas, while it is difficult enough to estimate the actuarial value of future defined pension benefits, an employer offering future defined health benefits generally has no idea just what these service benefits might be, let alone what they might cost, because technological advances are so rapid in health care.[3] Exhibit 2 suggests something about the potential fiscal consequences of such promises. As is shown in the exhibit, average annual per capita health care expenditures for Americans under age sixty-five currently run at about $1,287. For the aged, these costs average $5,360 per capita and rise steeply with age. Medicare pays on average less than half of the health care costs incurred by the aged. Private sources, American business firms prominent among them, pay about 37 percent.

One may charitably view the widespread offering of postretirement health benefits as benevolent—albeit financially reckless—paternalism on the part of American executives and labor leaders seeking to act with

Exhibit 2
Per Capita Expenditure On Health Care, United States, 1987

Age cohort	Spending per capita	By source of funds		
		Private	Medicare	Other
Under 65	$1,287	$ 947	$ 41	$ 299
65 and over	5,360	2,004	2,391	966
65–69	3,728	1,430	1,849	449
70–74	4,424	1,564	2,234	625
75–79	5,455	1,843	2,685	927
80–84	6,717	2,333	3,023	1,361
85 and over	9,178	3,631	3,215	2,333

Source: D.R. Waldo et al., "Health Expenditures by Age Group, 1977 and 1987," *Health Care Financing Review* 10, no. 4 (Summer 1989): 116–118, Tables 3 and 4.

social responsibility. In a less charitable interpretation, this practice may be viewed as a dubious method of procuring labor and securing industrial peace, for the long-run cost of this practice has always been carefully hidden from a firm's owners.

Under our Generally Accepted Accounting Principles (GAAP), business firms must accrue as part of payroll expense the present (actuarial) value of the pension liability triggered by the employee's service in the year that service is rendered, and not just when these benefits are paid out in cash. Furthermore, under the Employment Retirement Income Security Act (ERISA) of 1974, it is generally required that employers *fund* these future liabilities in the period the employees' service is rendered.

Remarkably, neither stricture has hitherto been applied to promised postretirement health benefits. Most corporations have booked outlays on such plans on a pay-as-you-go basis, charging them to income only in the year when the required health expenditures were made on behalf of the then retired employees. One may fairly label this form of financial reporting practice as Louis XIV accounting ("*Après moi, le déluge!*"), for it permits management teams in one period to shift expenses for which they are obligated to future periods presided over by different management teams.

Offering defined benefits of this sort, on a pay-as-you-go basis, without full disclosure of their approximate actuarial cost, may have been a seductive idea in the pastoral years following World War II, when the United States was free to dictate the world economic order and when the typical American corporation could assume that its economic position was secure forever. Unless such promises are substantially funded when they are made, however, they are usually highly reckless. They are certainly reckless in today's uncertain, highly competitive world economy that exposes the revenue stream of even giant American business firms to managerial decisions made in faraway Asia and Europe.

To be fully responsible, American industry and labor should shift away from defined health benefit plans toward the more viable defined-contribution plans. Ideally, one would like to see Congress enact compulsory, defined-contribution plans for acute and long-term care. Such savings plans should be fully vested, should come out of pretax earnings, and could be managed either by the public sector or by approved private plans, as is the custom in Europe. Finally, they should be supplemented with public subsidies for low-income employees who could not under any circumstances accumulate sufficient savings to finance their retirement.

Unfunded liabilities. But even if American business did shift away from defined-benefit to defined-contribution plans for retiree health benefits, what of the enormous unacknowledged and unfunded

postretirement health benefit obligations soon to be highly visible on the books of American business? Under a proposed new ruling by the Financial Accounting Standard Board (FASB), employers will be required, after 1992, to report the estimated future cost of postretirement health benefits on an accrued basis, just as they now must report the actuarial cost of defined pension benefits. The Employee Benefits Research Institute (EBRI) recently estimated the total amount of unfunded liability for benefits already promised at about $170 billion for American business as a whole, although other estimates have put the number multiples higher.[4] For some individual firms, this hitherto unacknowledged and unfunded prior service obligation equals substantial portions of net worth.

The question arises whether the sudden accounting recognition of this obligation, and its eventual amortization through the payment for retiree health benefits, will not by itself erode the competitive position of American industry in the world economy. Here we must distinguish between mere accounting entries and future cash flow.

Technically, the recognition of this hitherto unacknowledged prior service obligation in the firm's books is just an accounting formality. There will be a debit (or a time-phased series of debits) to the firm's net worth accounts (that is, shareholders' equity) and a corresponding credit (or series of credits) to an account labeled "Unfunded Liability for Postretirement Health Benefits," or something like that. This entry by itself does not alter the firm's current or future liquidity. It merely alerts sleepy shareholders to the fact that a substantial portion of what management had always reported to them as "shareholders' equity" actually had been quietly given away to labor long ago by the firm's executives, some of whom may already be happy recipients of these postretirement health benefits by the time the revealing journal entry must be made.

Impact on shareholders. And what of the market price of the firm's stock? Might it not plummet in response to this shocking accounting revelation? Probably not just then. In today's alert securities markets, there typically will have been an appropriate downward adjustment in the price of the firm's stock long before the FASB eventually forces this candid journal entry upon management. Indeed, the ongoing lengthy discussion of the FASB exposure draft on its proposed ruling has by now let all of the relevant cats out of the bag. These cats must by now have been fully counted by the nation's security analysts.

But what of the sizable cash outlays American business firms will have to make in the future, either to prefund their postretirement health benefit plans or to pay for health benefits when retirees receive them? Might not this drain on corporate funds—cash outlays for workers who

do not even work for the company anymore—render American industry noncompetitive in world markets? Here the proverbial two-handed economist can answer with an equally firm "Yes" and "No."

"Yes," if American industry insists, against all reason, on seeking to fund these cash outlays through higher product prices, come hell or high water, even at the risk of quiet suicide in the global product markets. "No," if American industry sees the light, prices its products competitively, and then funds this cash drain out of shareholders' current cash income, as best it can. After all, it was management in its role as shareholders' agent who made these commitments to workers on the principals'—the shareholders'—behalf. It is therefore only reasonable that shareholders be made to absorb the cost of honoring these promises. Indeed, it is in anticipation of just these future hits upon shareholders that the market price of the firm's stock will tend to drop as soon as the extent of this future cash drain becomes known to the financial markets.

The impoverishment of existing shareholders through management practices that had been carefully hidden from these shareholders for so many years may, at first sight, strike one as manifestly unfair. But does lack of candor on the part of earlier managements really entitle shareholders to public relief? One should think not.

Although the ideal of our industrial democracy calls for forthright financial accounting on the part of management, our Generally Accepted Accounting Principles certainly cannot guarantee it, nor does management invariably strive for it. Lack of forthright financial reporting on the part of management is but one of the many risks that shareholders assume when they invest in a company's stock. In return, shareholders do earn long-run rates of return far in excess of the rates paid on better-protected investments. In a sense, shareholders have already been prepaid for such contingent losses.

Other options for business. Do current and future managements have other options to fund their postretirement health benefits, other than hitting upon trusting shareholders? Perhaps. A desperate enough corporate America may seek to pass the cost of these benefits back to retired employees simply by "modifying" its earlier promises. Management's ability to do this is currently being tested in the courts. Should those firms seeking that relief prevail and eventually nibble away at the postretirement health benefits they had promised their workers, the retirees who recently celebrated their successful lobby against the Medicare catastrophic legislation may yet come to rue their victory and return to Congress, hats in hand, like prodigal sons (and daughters).

On the other hand, should management lose in the courts, there always remains the option simply to nationalize the private agony. The

growing plea for national health insurance by some American business leaders is one variant of this strategy. For example, business might argue that a Congress willing to cover with taxpayers' funds the ludicrous and often corrupt mistakes of the savings and loan industry, to an estimated tune of $200 billion, ought also to be willing to foot with taxpayers' funds a similar bill for the much more nobly inspired, if reckless, attempts by American business to offer employees private, business-financed social security systems. It would not be difficult to develop some sympathy for that line of argument, and, conceivably, it might find a receptive audience in some Congress a decade hence. It is likely to fall on deaf ears now and in the near future.

Of course, even if the present health insurance system were replaced with a tax-financed national health insurance system of the sort recently advocated by David Himmelstein and Steffie Woolhandler, the cost of health care would not necessarily vanish from the income statements of American business.[5] Such a system might be financed wholly or in part with payroll taxes, as is the case in West Germany and in many other European nations. Alternatively, the system might rely partially on corporate income taxes as a source of financing. Such a system, however, might still relieve business firms encumbered with huge unfunded liabilities for postretirement health benefits by shifting part of these liabilities to other business firms and, in the end, to those who bear the ultimate incidence of taxes levied upon the business sector.

Competitiveness From A Macroeconomic Perspective

Quite aside from this analysis at the microeconomic level of the individual firm, it is sometimes argued, at the macroeconomic level, that the *overall* percentage of GNP devoted to health care in our economy is too high for the nation's long-run competitiveness, because it comes at the expense of capital formation. This argument goes as follows:

> A nation can allocate its GNP to current consumption or to investments in productive capital. (The portion of GNP that is not consumed represents the much-discussed "national savings ratio.") It is generally agreed that capital formation enhances the productivity of labor. It can thereby lower the labor cost per unit of output and, thus, product prices.
>
> The United States has traditionally exhibited one of the highest ratios of consumption to GNP in the industrialized world (that is, one of the lowest savings ratios). Our relatively high spending on health care is part of that high consumption (low savings) ratio.[6] Japan, for example, spends only about 6.5 percent of its GNP on health care. The United States now spends about 11.5 percent. Relative to the United States, Japan therefore could spend about four percentage points more of its GNP on research, product development, and other productivity-enhancing capital investments than we

> do, and still leave the same percentage of GNP as we do for all other things. Indeed, it is precisely its traditionally high rate of national saving and capital formation, rather than cheap labor, that makes Japan so price-competitive in the global market today.

An alternative macroeconomic argument couches its reasoning not in terms of an assumed inverse relationship between national health spending and the national savings ratio, but on the allocation of scarce productive resources to competing uses. This version of the macroeconomic argument proceeds as follows:

> Our health sector now absorbs many scarce real resources (scientists, engineers, doctors, other labor at various degrees of skill, brick, mortar, equipment, and so on) that could be deployed in the production of superior consumer electronics, cars, cameras, and supercomputers, and is so deployed in Japan and in other countries that spend a smaller fraction of their GNP on health care. To remain competitive with these other nations, we had better divert scarce human talent and other real resources away from health care and into other economic sectors that make import- or export-competitive products.
>
> For example, instead of drawing so many good minds into medicine and allied health professions, we should persuade young people to become scientists and engineers who devote their life to making better consumer electronics, cameras, computers, and the like, that could then be produced more cheaply in the United States and competitively priced in the world market.

There clearly is something to these macroeconomic arguments. It is not so clear, however, why they should focus strictly on health care as the chief culprit, particularly when there are so many highly intelligent Americans who spend all of their energy and intellect merely redistributing claims to the nation's useful output, rather than creating net additions to useful output themselves. One thinks here, for example, of the huge tax-avoidance industry that helps Americans pass their tax burdens around like hot potatoes, of the huge legal industry that helps Americans sue one another in strictly negative-sum games, or of the equally huge advertising industry, some of which may well disseminate useful information, but much of which simply moves customers around in negative-sum games.

Indeed, the question can be broadened further. In 1987, Americans spent a total of $194 billion on hospital care, $102 billion on physician services, and $34 billion on drugs and sundries.[7] These are sizable outlays. On the other hand, in the same year, Americans were willing and able to spend $35.6 billion on tobacco products, $61 billion on alcoholic beverages, $24.2 billion on jewelry and watches, and $26.2 billion on toiletries and preparations.[8] It can be asked why, if reduction in the national consumption ratio is the objective, or if scarce resources are to be channeled to superior economic uses, we should not divert real resources

away from yet other economic activities—for example, from the entertainment industry or from our large transportation industry—all of which absorb human labor of varying skills and other resources that might be put to better uses? But therein surely lies the crux of the matter: the key words are "better use," and we must ask, "better" in whose eyes?

In the end, then, the macroeconomic argument against spending on health care boils down to the perennial question over the relative benefits and costs associated with shifts of real productive resources among different economic sectors and from consumption to savings. The argument should be styled something like this:

> If Americans do wish to constrain their overall spending on consumption for the sake of capital formation or to shift real resources toward more productive activities, such as consumer electronics or computers, it is better to draw away the requisite real resources from health care rather than, say, from the production of alcohol and tobacco, from the advertising industry, from the legal industry, from the entertainment industry, from the media, or from transportation and the like, *because all resources in these other sectors are still "more productively used" than are many the resources now devoted to health care, where real resources are so often wasted.*

In this context, the term "more productively used" means that, even at the margin, the deployment of real resources in these other sectors bestows relatively greater satisfaction ("social value") upon Americans than do many of the resources now deployed in the health care sector, even if these other sectors produce alcohol, tobacco, and the like.

A full development of this issue goes much beyond the scope of this essay. It requires one to come to grips with the definition of "social value." It is customary in our latitudes to let the "social value" of ordinary consumer commodities—such as bread and shoes and gin—be defined by the willingness to pay with one's own money. By contrast, the "social value" of a medical treatment given to a particular person may vastly exceed the maximum amount of money that person may have been able and willing to pay for the treatment, because a community may wish to see a person receive treatments he or she would not be able to afford with his or her own resources. In the context of health care, benefits and costs are not easily measured.

At this point, we merely note that the macroeconomic case against added spending on health care rests on the allegation that, among the many sectors of our economy, the health care sector is unusually wasteful. It absorbs real, productive resources to produce services whose "social value," however defined, does not cover their social opportunity costs in terms of the forgone output these resources might have produced elsewhere.

We do not usually make this allegation in connection with ordinary commodities—including handguns, alcohol, and tobacco—because total spending on such commodities is thought to represent the sum of a myriad of individual, voluntary transactions in each of which the buyer makes certain that the benefits yielded by the commodity cover opportunity costs of producing it. Because of the presence of third-party payment (and also because patients tend to be ill-informed, sick human beings and not regular consumers), we cannot assume that each health care transaction successfully passes a proper benefit/cost hurdle. Hence we suspect a large potential for waste, particularly when health care is paid for on a fee-for-service basis.

On this suspicion—and on some supporting empirical evidence that fuels the suspicion—rests one part of the macroeconomic case for health care cost containment.[9] The remainder of the argument has to do with the many demands, and fiscal constraints, Americans impose upon their public sector.

Constraints Posed By Fixed Public Budgets

If there is one macroeconomic link by which high health care expenditures are likely to detract from the nation's competitiveness in the long run, it probably resides in that portion of total national health expenditures financed through public budgets (about 42 percent at this time). For decades now, the lips of American taxpayers have formed the words, "No tax increases!" Not only have our politicians dutifully paid homage to that wish, they have sanctified and fueled it in every recent election campaign. Total taxes in this country at all levels of government have, in effect, fluctuated very narrowly around a fixed level of 33 percent of GNP since 1970, in spite of an aging population and a growing underclass of poverty-stricken children. With the possible exception of Japan, we still have the lowest overall tax burden among nations in the Organization for Economic Cooperation and Development (OECD), where tax-to-GNP ratios in the mid-to-high 40 percent range are typical.

Given this relatively small, fixed *public* budget, every dollar the American public sector must spend on health care must come at the expense of other public expenditures—including spending on the nation's public infrastructure and on education. In recent years, however, we have financed some parts of public spending simply with public debt.

American children now receive an average of only 180 days of schooling per year, compared with 220 days or so in Europe and 240 throughout the Pacific rim. Survey after survey reveal that America's children lag academically relative to their contemporaries abroad. A good case could

be made, on grounds of both fairness and efficiency, for lengthening the school year in this country by, say, forty days a year to keep our children competitive with children elsewhere. This expansion of the school year would cost money, of course. Alas, as noted, the American taxpayer chants: "No way!" Alas, too, American governments at all levels are under constant pressure to spend more on health care, lest they stand accused of "rationing" care.

It is through this peculiar mechanism—rigidly fixed public budgets and ever-rising claims of health care on these fixed budgets—that health care today may mortgage our nation's future competitiveness. The end result of this mix of contradictory pressures is likely to be ever more neglect of human capital formation (education) in this country and similar neglect of our public infrastructure that is such a crucial contributor to productivity growth.

The myopic political imperatives of the 1980s have placed government in an untenable position. Rightly or wrongly, the American people have promised Medicare coverage to *all* aged, rich or poor. The implied burden on the public purse can only grow. In addition, however, somewhere between thirty and thirty-five million Americans currently have no health insurance coverage whatsoever. Most of these uninsured are low-wage, full-time employees of small business firms or their dependents. One-third of them are children.

To provide the uninsured with access to mainstream American health care requires that better-off Americans somehow pick up the tab. If this transfer cannot be effected openly through the government, via taxes and public health insurance programs (or public subsidies toward private coverage), then we shall face some stark choices in America. Either we must abandon the low-income uninsured and simply ration them out of the health care system altogether—a policy already under way in many parts of the country—or we must use some forms of indirect taxation to effect the necessary transfer.

One form of such indirect taxation is the practice among providers of health care to shift the cost of uncompensated indigent care rendered by them to paying patients who, in turn, are insured by the business sector. An alternative, somewhat more direct form of such taxation would be simply to mandate employer-paid health insurance upon all business firms, large and small. Mandated employer-paid benefits are taxes in all but name. Finally, the public sector could seek, as it already has, to spread its constrained budgets over more people by paying prices below fully allocated costs for the health care it finances—a practice commonly known as "cost shifting"—leaving private-sector, paying patients and their insurers to pay for the uncovered overhead. Given the large share of

the health care market accounted for by the public sector, it has the market muscle to extract such discounts.

There is something unseemly about these indirect forms of taxation, because their chief purpose is to camouflage their ultimate incidence. But in a nation unwilling to tax finance openly the government's urgent tasks, indirect taxation through these various forms of cost shifting may well make perfect economic sense from a longer-run perspective.

Concluding Remarks

None of the preceding arguments should be taken to represent a case against efforts on the part of business to control its own ever-growing outlays on health care benefits. On the contrary, business would do well not to pay for health services of dubious medical merit, and also to minimize the money prices it pays for whatever health services it does procure on behalf of employees. After all, every dollar wastefully or needlessly spent by employers on health care impoverishes at least one of the firm's stakeholders, and, almost always, it is employees who pay the bulk of that price in the form of lower real cash income, at least in the longer run.

Even if every increase in the cost of employer-paid health care benefits could immediately be financed by the firm with commensurate reductions in the cash compensation of its employees—so that "competitiveness" in the firm's product market is not impaired—it would leave employees worse off unless the added health spending bestowed upon employees is valued at least as highly as the cash wages they would forgo to finance these benefits.[10] Because it is the perceived value of a firm's compensation package that lures workers to the firm and away from competing opportunities, the typical business firm has every economic incentive to maximize this perceived value per dollar of health care expenditure debited to the firm's payroll expense account. Therein, and not in "competitiveness" on the product side, lies the most powerful rationale for vigorous health care cost containment on the part of the American business community.

This essay is based on an earlier letter written to the employee-benefits manager of a large American corporation. I thank David E. Card of Princeton University's Department of Economics and Robert H. Sprinkle of Princeton's Woodrow Wilson School for their valuable comments on an earlier draft. Mark V. Pauly of the University of Pennsylvania commented extensively on the earlier letter and sent along some pertinent papers of his own that make similar points. Any remaining errors or faulty logic in the present essay are, of course, solely the author's responsibility.

NOTES

1. *The New York Times*, 14 November 1989, B1.
2. D. Fraser, in "A National Health Policy Debate," *Dartmouth Medical School Alumni Magazine* (Summer 1989): 30.
3. Typically, a defined-benefit plan pays future pension benefits that are defined by the worker's years of service to the company and by the average income during the later stages of the work life. The actuary trying to estimate what sum must be set aside in the current year to own up to the pension obligation generated by the worker's service in the current year must predict long-time series of future interest likely to be earned on funds set aside in a pension fund, the worker's age of retirement, future quit rates, future wages and salaries, and future inflation. In short, the so-called actuarial *service cost* of a pension benefit is at best a rough "guesstimate."
4. Employee Benefits Research Institute, *Issue Brief* 84 (November 1988).
5. D.U. Himmelstein and S. Woolhandler, "A National Health Program for the United States," *The New England Journal of Medicine* 320, no. 2 (12 January 1989): 102–108.
6. Actually, spending on health care can be one of the more productive investments a nation can make if it prevents future illness or restores sick individuals to a healthy, productive life.
7. S.W. Letsch, K.R. Levit, and D.R. Waldo, "Health Care Financing Trends," *Health Care Financing Review* 10, no. 2 (Winter 1988): 115, Table 3.
8. U.S. Department of Commerce, *Survey of Current Business* (July 1989): 52, Table 2.4.
9. For an excellent survey of such evidence, see R.H. Brook and M.E. Vaiana, *Appropriateness of Care: A Chart Book* (Washington, D.C.: George Washington University, National Health Policy Forum, June 1989).
10. Under current tax laws, compensation in the form of health benefits is not taxable income, while cash compensation is taxable income. That tax treatment biases the benefit/cost calculus in favor of employer-paid health benefits.

Health Care Woes Of American Business: Reinhardt Responds

by Uwe E. Reinhardt

To have one's statements subjected to critical, public review can be a pain, or it can be an honor. Given the distinguished cast of characters taking aim at my essay in this instance, I feel honored, and also grateful for the additional perspectives they contribute to the issue I sought to illuminate—namely, whether health spending *per se* renders American industry noncompetitive in the international marketplace.

To think about that issue, one had best decompose it into the following quite distinct questions:

> (1) Would one judge spending on health care in the United States excessive, even if none of it flowed through the payroll expense accounts of American business firms?
> (2) Is the competitive position of American business firms hurt by having so much of American health spending flow through the payroll expense account?

Don't blame health care. It is now widely taken for granted that the answer to the first question is "yes." Walter Maher, for example, refers to the "inefficiencies infecting America's health care system" and asserts that "as a result of these excesses, Americans spend about 40 percent more per capita on health care than does the second most expensive country in the world (Canada)." Walter McNerney, for his part, states that "[health care] costs are out of control and the mechanisms are not there either to keep them reasonably in line or to produce value."

As I mentioned in my essay, these propositions do find support in a growing body of empirical research on the "clinical appropriateness" of American health care. My central focus, however, was not that issue, but the second question highlighted above. Here I had argued that, as long as firms voluntarily offer their employees health insurance, one had best view such fringe benefits as part of a total, market-determined compensation package whose various components are traded off against one another in the longer run. On that theory, it does not make sense to pick out one of these components and blame it for problems American business faces in pricing its products.

Remarkably, along with Maher and Monte DuVal, Carl Schramm of the Health Insurance Association of America (HIAA) doubts the validity of this conventional theory, which Maher writes off as "academic." Schramm argues that the real world lies on the short side of the economist's imaginary long run and that, in the short run, cash wages cannot as easily be reduced in the face of increases in employer-paid health insurance benefits, as the standard economic theory predicts. It follows, he argues, that increases in fringe benefits are apt to reflect themselves in either increased product prices or lower profits and "thus do affect

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the competitiveness of products in international markets."

Should health insurance be employer-centered? Schramm's proposition, it must be noted, is not at all dependent upon there being waste in American health care. His argument therefore leads to the politically charged question, posed crisply and explicitly by McNerney at the end of his comment, whether health insurance linked to employment in the American way—the main staple of HIAA's membership—actually ever was the most sound basis on which to build American health care financing.

I had not raised that delicate issue in my essay, because my "academic theory" renders it moot. I am therefore all the more surprised by Schramm's thesis, and even more so by Doug Peters's assertion that "Reinhardt's essay reflects his preference for nationalized systems." Here Peters obviously reacts to a phantom projected instinctively from the deep recesses of an American insurance executive's own troubled soul. That soul has been haunted of late not by me but by the current fascination all across America with Canada's government-financed health insurance system and also, I suspect, by the large increases in premiums American health insurers have been forced to levy upon American business during the past several years.

Although I personally have long admired Canada and West Germany for their ability to legislate and operate their national health insurance systems, apparently to their citizens' relatively high satisfaction, I have also learned after some twenty-five years in the United States that there are two things Americans just cannot seem to do, for reasons only an anthropologist can understand. First, they cannot make a railroad run on time; second, they cannot legislate, let alone operate, a lean, streamlined, publicly financed human services system. They demonstrably cannot do it in education; they demonstrably cannot do it in jurisprudence; and they probably could not do it in health care either. Consequently, I have for some time now advocated, for this country only, a two-track health insurance system: an employment-based system that is privately financed, coupled with a federally financed fail-safe insurance system for anyone not privately insured (see "Health Insurance for the Nation's Poor," *Health Affairs*, Spring 1987).

As Schramm points out in his remarks, it is excruciatingly difficult to settle, with non-experimental data, theoretical arguments over the ultimate impact that fringe benefits have on output prices, wages, and profits. Let us therefore not linger on the validity of my "academic theory" or on how long the "long run" is in the so-called real world. Let us instead turn to a number of temerarious questions that can fairly be put to America's hand-wringing business leaders.

Questions For U.S. Business

Improving competition. The first question, touched upon ever so bluntly by Sam Mitchell, is this: Do American business leaders really believe that, if by some miracle we succeeded in reducing annual health expenditures to, say, 9 percent or so of gross national product (GNP), Detroit would then be ready to design price- and quality-competitive Miata-, Infiniti-, or BMW-like cars, that Rochester would then be ready to produce attractive Minolta- or Fuji-like cameras, that RCA would then design and manufacture Sony-like Walkmans, compact disc players, and Camcorders? I very much doubt that reductions in merely one component of payroll expense could trigger the major cerebral metamorphosis such a shift would require. Only brutal and unrelenting competitive pressure from abroad and the attendant lessons in product design, quality control, and industrial leadership will ever achieve that metamorphosis.

As McNerney aptly remarks on this point:

> In several key U.S. industries, in the 1970s and early 1980s, poor competitive showings, domestically and internationally, were clearly the result of lack of attention overall to productivity.... Many [American business firms] had simply grown too fat and bureaucratic, starting at the top. The drift into poorly designed health benefits was simply one manifestation of decline, not the cause.... [E]mployers

> have been reluctant, or unable, to trade off {wages and fringe benefits} aggressively and often, as a result, let overall compensation get out of hand.... This *has* affected competition—not because of what employers could have done, but because of what they did.

Probably no industry illustrates McNerney's point better than Maher's own. The auto industry, along with the steel industry, has for years bestowed extraordinarily generous compensation packages upon both its workers and its executives. To protect these generous incomes from the forces of the marketplace, the industry's leaders thought nothing of having President Reagan ask Japan's auto industry in 1981 to form the OPEC-like Japan Automobile Export Cartel, felicitously called the "voluntary export quota." The sole purpose of this quota, which continues in some form to this day, has been to limit artificially the supply of Japanese cars to America, thereby forcing up their prices stateside. These price hikes, in turn, have provided American automobile manufacturers with a protective umbrella that has allowed them to raise their own prices (and incomes) in step.

It is proper to view these artificially forced price hikes as an excise tax upon American consumers—a tax, however, that accrues to the protected producers, not government. Economists at the Brookings Institution and at the Federal Trade Commission have variously estimated this excise tax at somewhere between $500 and $1,000 per automobile sold in the United States, or between $150,000 and $200,000 per year per American automobile job saved by the quota. Worse still, the quota has postponed for American manufacturers the day of full reckoning with truly efficient, lower-cost automobile producers elsewhere in the world; it is itself a barrier to full competitiveness. Frankly, I find it ironic that industrialists who have protected their own incomes and managerial habits in this way should now look to the health industry as the source of their travails in the product markets.

Buying quality. But leaving aside that irksome issue, we may fairly ask America's business leaders yet another blunt question, namely: If you are so convinced that you are overpaying doctors and hospitals and buying from them inefficiently produced services, many of them completely unnecessary, why do you do it? Do you buy steel that way, or copper wire, or air travel? If not, then why set aside prudent purchasing when it comes to health care?

The rejoinder may be that American business leaders know from the available research that there is enormous waste in American health care, but that they cannot pinpoint that waste. My next question then would be: What have American business leaders done to remedy that situation? Specifically, in the past decade or so, how many dollars has the powerful Business Round Table contributed to the research of clinicians and epidemiologists who have devoted their professional lives to this question? How many dollars have been contributed by the automobile industry, which leads the chorus in complaints over waste in health care? How many dollars will American business contribute to this research task in the decade ahead?

So far, American business leaders have been wailing pitiably and pitifully at being run over by a wasteful "health care juggernaut," with nary a thought given to the question of just who should finance the production of the information necessary to help physicians practice and payers purchase more cost-effective medicine. America's chief executives have been sitting on their hands on that particular task, leaving it entirely to the much-maligned federal "bureaucrats" in the Department of Health and Human Services, whose early vision on this matter is chiefly responsible for funding the assembly of the revealing information we now do have on "inappropriate" health care.

Both DuVal and Mitchell harshly criticize American business leaders for having built the very cost trap they now lament. I wholeheartedly concur. It was business that first hit upon the idea of linking health insurance to employment in the uniquely American way; it has been business that to this day has lobbied to have the enormously generous health care entitlements they

promised their employees sheltered from income taxation; and, as I noted in my earlier essay, it has been America's business leaders who promised their workers these entitlements even during retirement, without informing shareholders of the actuarial cost of such promises. McNerney seems to suggest that the latter omission was not outright lack of candor, but mere uncertainty about the future cost of retiree health benefits. I am more inclined to agree with Schramm, who suggests (in another context) that these business leaders are "highly paid, highly intelligent managers." Surely they must have known full well what they were doing when they hid the cost of retiree health benefits from those who ultimately will pay for them: the firm's owners.

Intellectual gridlock. Most striking from a detached perspective is the intellectual gridlock that has now befallen American business on the issue of health policy. Suppose, for example, President Bush were toying with the idea of a major health policy initiative and that, to be safe, he booked some hundred executives of large and small business firms into Washington's Willard Hotel with the mandate to produce, in a day or two, a coherent national health care strategy. I rate the chance slim that, aside from certain highly abstract platitudes about the virtue of free markets and the dictum that every American should have access to needed, high-quality care, any such set of one hundred executives would be able to articulate a concrete, coherent, and administratively feasible legislative package all of them would support or, at least, none of them would sabotage. Therein, I submit, lies the chief health care problem besetting American business today and, indeed, all of American health policy.

Corporate support for physician payment reform. Let me be even more specific. Congress has recently passed into legislation a fee schedule for physician services that is based on estimated relative resource costs. Relative to the fees currently paid by Medicare, the new schedule will raise the fees for primary care physicians by up to 30 percent and reduce those for certain surgical and diagnostic procedures by up to 30 percent below levels currently paid by Medicare, and even further below the much more generous fees American business now pays for such procedures through its insurance programs.

So far, American business does not seem even to have taken cognizance of this dramatic development, although it should have been an integral part of the underlying research and policy initiative from the very start. The interesting question, whose answer is left for the reader's own conjecture, is this: What will American business do when the new fee schedule takes effect? Will it come on board with the new fee schedule—which, incidentally, has substantial support among physicians (proceduralists excepted)? Or will business continue to pay the proceduralists the much higher fees it currently pays them, deriding the leaner Medicare schedule as "government regulation," thereby possibly making it difficult for Medicare to secure adequate access to health care for the aged?

Or will American business leaders do neither and instead engage in what Sony Corporation Chairman Akio Morita and other Japanese business leaders have identified as a disturbing new trend among their American counterparts: a penchant for whining and looking around for scapegoats, rather than managing. In this case, they are whining about an alleged "cost shift" from Medicare to the private sector and about the insatiable "health care juggernaut" rather than learning how to confront that juggernaut effectively. They also must confront their own employees, whom these business leaders have taught for so many years, as DuVal reminds us, that completely unconstrained and free access to whatever health care strikes one's fancy is an American worker's inalienable entitlement.

We shall see in the decade ahead. Let us hope that Chairman Morita has it all wrong.

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PROVIDING ACCESS TO HEALTH CARE AND CONTROLLING COSTS:
Approaches abroad, Options for the United States

The human condition surrounding the delivery of health care is everywhere on the globe the same:

> *The providers of health care seek to give their patients the maximum feasible degree of physical relief, but overall (if not for every patient they treat) they also seek a goodly slice of the GNP, in the form of money-vouchers, as a reward for their efforts.*
>
> *Patients seek from the providers of care the maximum feasible degree of physical relief, but collectively (if not in each and every every case) they also seek to minimize the amount of GNP that must be granted the providers as a reward for the their efforts.*

In other words, while there typically is a meeting of the minds between patients and providers on the *clinical* side of the health-care transaction, there very often is conflict on the *economic front*. It has always been so, since time immemorial, and it will always be so, from here to kingdom come. It is part of the human condition.

Health insurance does not lessen this perennial economic conflict; it merely transfers it from the patient's bedside to the desk of some private or public bureaucrat charged with guarding a collective insurance treasury.

But health insurance does realign the parties to the economic fray. Because insurance shields patients from the cost of their medical treatments at point of service, it tends to move them squarely into the providers' corner when they are sick. Usually, in that corner, they rail against the heartless bureaucrats who refuse to surrender the key to the collective insurance treasuries they are there to guard. When patients are healthy and faced with mounting taxes or insurance premiums, on the other hand, they are typically found in the bureaucrats' corner. In that corner they rail against the voracious financial appetite of health-care providers.

Such is the intellectual purview from which the proverbial man and woman in the street beholds the health-care sector. That, too, is part of the human condition.

I. CONTROLLING THE TRANSFER OF GNP TO PROVIDERS

Society can control the total annual transfer of GNP to the providers of health care through the demand side of the health care market, through its supply side, or through both. Nations differ substantially in the mix of approaches used to this end. Their choice of cost-control policies hinges crucially on the social role that is ascribed to health care. The two extremes of the spectrum of views one may have on this issue are:

1. Health care is essentially a *private consumption good* whose financing is the responsibility of its individual recipient.

2. Health care is a *social good* that should be collectively financed and available to all citizens who need health care, regardless of the individual recipient's ability to pay for that care.

Canadians and Europeans have long ago reached a broad social consensus that health care is a *social good*. These countries have erected their health policies firmly and consistently on that basic ethical precept. Americans, on the other hand, have never been able to reach a similarly broad, political consensus on just where on the ideological spectrum defined by these two extreme views they would like their health-care system to sit. Instead, American health policy has meandered back and forth between the two views, in step with the ideological temper of the time. This meandering has produced contradictions between professed principles and manifest practice that amuse the foreigner and confuse even the initiated at home. For example, at this time in the nation's history, poor, uninsured Americans often find it difficult to gain access to health-care resources of which the nation has too many.

A. The Social-Insurance Approach in Canada and Europe

As noted, Canadians and Europeans typically view health care as a *social good*. In these countries it is anathema to link an individual household's contribution to the financing of health care to the health status of that household's members. Health care in these countries is collectively financed, with taxes or premiums based on the individual household's ability to pay. Only a small well-to-do minority--so far less than 10 percent of the population--tends to opt out of collective, social insurance in favor of privately insured or privately financed health care. Over 90 percent of the population in these countries typically share in common one level of quality and amenities in health care.

Control over health-care costs in these countries is exercised primarily by controlling the capacity of the *supply side*. The chief instrument for this purpose is formal regional health planning. Planning enables policymakers to limit the number of hospital beds, big-ticket technology such as CAT-Scanners or Lithotripters, and, sometimes, even the number of physicians issued billing numbers under these nation's health-insurance systems.

Regulatory limits on the capacity of the health system inevitably create monopolies on the supply side. To make sure that these artificially created monopolies do not exploit their economic power, these countries always couple health planning with stiff price- and budgetary controls. Where the intent of price controls has been thwarted through rapid increases in the volume of health services rendered, for example, these countries eventually impose strictly limited global budgets on hospitals and doctors. Thus, Canada has long compensated its hospitals through pre-set global budgets. Similarly, West Germany now operates strict, state-wide expenditure caps for all physicians practicing within a state under the nation's Statutory Health Insurance system. The United Kingdom and the Nordic countries budget virtually their entire health systems.

Figure 1 illustrates this three-pronged approach to health-care cost-control: (1) limits on physical capacity, (2) limits on fees and prices and (3) limits on overall expenditures.

[Figure 1]

To effect their price- and budget controls, Canada and the European countries tend to structure their health-insurance systems so that money flows from third-party payers to the providers of care only through one or a few large money-pipes whose money-throughput is then controlled through formal negotiations between regional or national associations of third-party payers and associations of providers. As already noted, usually the negotiated prices in these countries are binding upon providers, who may not bill patients extra charges above these prices. Although France permits extra billing within limits, most of these countries see unrestrained extra billing as a violation of the spirit of health insurance.

The extreme version of this payment policy is illustrated in the bottom panel of Figure 2. It is the approach used in the typical Canadian province, where the provincial government administers both the hospital-insurance and the physician-service insurance plans.

[Figure 2]

Remarkably, and in sharp contrast to the United States, Canada and Europe typically do not look to the individual patient as an agent of cost control: usually there is not a significant flow of money from patient to provider at the time health services are received. Instead, most of these countries provide patients with comprehensive, universal, *first-dollar* coverage for a wide range of services, typically including drugs (although Canada covers these only for the poor). France does have some co-payments at point of service, but usually not for serious illnesses. Furthermore, many French patients have supplemental private insurance to cover any co-payments.

FIGURE 1

THE CANADIAN/EUROPEAN APPROACH

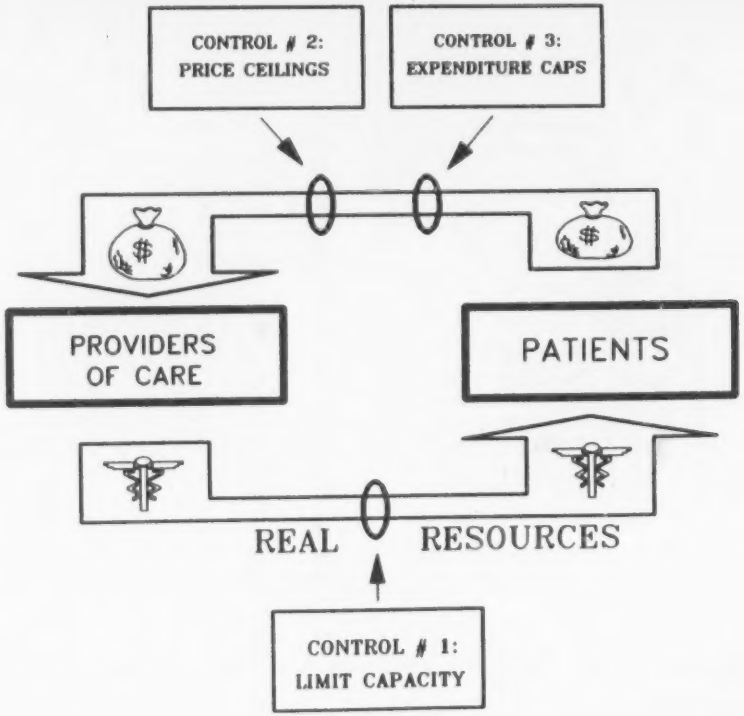
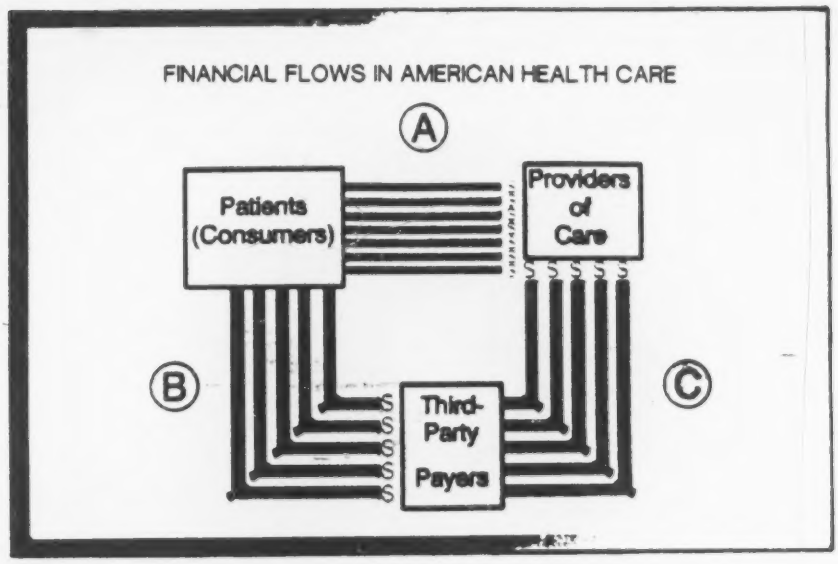
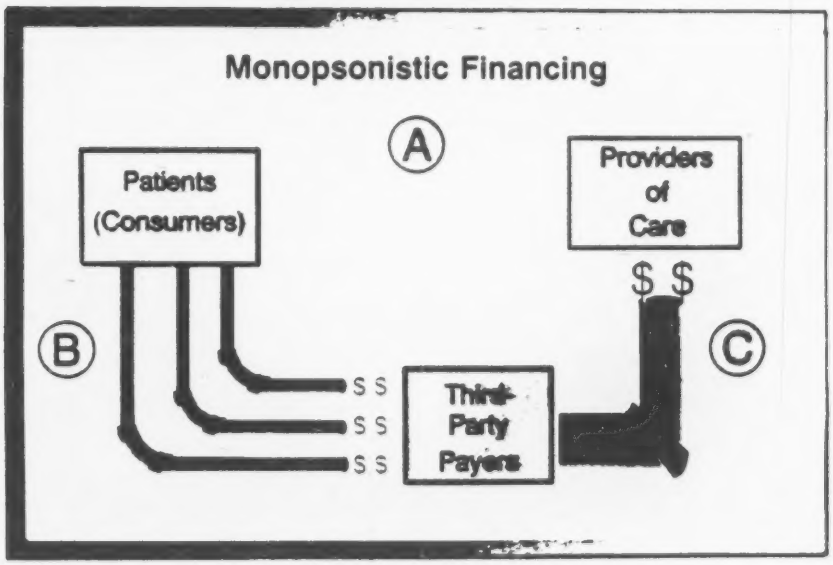


FIGURE 2

ALTERNATIVE FINANCIAL ARRANGEMENTS BETWEEN PATIENTS, PROVIDERS AND THIRD-PARTY PAYERS





One should not assume that Canada and the European nations eclipse patients from the chore of cost control because these nations' health-policy analysts and policymakers lack the savvy of their American colleagues who, in their debates on health policy, tend to style patients as "consumers" who are expected to shop around for cost-effective health care. Rather, one suspects that Canadians and Europeans are inclined to perceive patients as, for the most part, "sick persons" who should be treated thus. Table 1 suggest why that perception may be a valid one.

[Table 1]

As Table 1 illustrates, the distribution of health expenditures across a population tends to be highly skewed. In the United States, for example, only about 5% of the population accounts for as much as half of all national health expenditures in any given year, and 10% account for as much as 70% to 80% of all health spending (see Table 1). The distribution of health expenditures in other countries is apt to trace out a similar pattern.

One must wonder whether the few individuals who account for the bulk of health-care expenditures in any given year actually <u>can</u> act as regular "consumers" who shop around for cost-effective health care. Although cost-sharing by patients can be shown to have some constraining effect on utilization for mild to semi-serious illness, it is unlikely to play a major role in the serious cases that appear to account for the bulk of national health care expenditures.

Where price and ability to pay cannot ration health care, something else must. Usually, in Canada and in Europe, that non-price rationing device is a queue for elective medical procedures. At the extreme, some high-tech medical interventions--e.g., renal dialysis or certain organ transplantations--are simply unavailable to particular patients, if the likely benefits from the intervention are judged by the attending physician to be low.

More generally, high-tech innovations are introduced rather cautiously in these nations, and only after intensive benefit-cost analysis. At any given point in time, these nations' health systems are therefore likely to lag behind the United States in the degree to which a new medical technology has been adopted.

Finally, the tight control on overall outlays for health care tends to preclude the often luxurious settings in which health-care is dispensed to well-insured patients in the United States. Atriums and gourmet dining in hospitals, or physician office with plush, deep carpets are not common in Canada or in Europe.

TABLE 1

DISTRIBUTION OF HEALTH EXPENDITURES OVER THE U.S. POPULATION

(Selected Years)

PERCENT OF U.S. POPULATION	PERCENTAGE OF TOTAL HEALTH EXPENDITURES ACCOUNTED FOR BY THAT PERCENTILE OF THE U.S. POPULATION		
	1970	1977	1980
Top 1 percent	26%	27%	29%
Top 2 percent	35%	38%	39%
Top 5 percent	50%	55%	55%
Top 10 percent	66%	70%	70%
Top 30 percent	88%	90%	90%
Top 50 percent	96%	97%	96%

SOURCE: Berk, Monheit and Hagan (1988), Exhibit 1, p. 50.

B. The Entrepreneurial, American Approach

Americans have traditionally looked askance at regulation. To be sure, some regulatory controls of the supply-side of health care have been attempted at various times in a number of States (through so-called Certificate-of-Need laws) and there have also occasional flirtations with price controls (e.g., under Richard Nixon's Presidency, or in States that regulate hospital rates).

For the most part, however, Americans have always viewed the supply-side of their health sector as an open economic frontier in which any and all profit-seeking entrepreneurs may seek their economic fortunes. Indeed, traditionally Americans have seen the very openness of their health system to profit-seeking entrepreneurship as the key driving force that has made the American health system, in their own eyes, "the very best health-care system in the world."

American physicians, for example, have always prided themselves on their status as staunch "free-enterprisers" and they have vigorously, although not entirely successfully, defended that status against inroads by third-party payers. Furthermore, as historian Rosemary Stevens has shown convincingly in her recent IN SICKNESS AND IN WEALTH: A History of the American Hospital in the Twentieth Century (1988), even the nation's so-called not-for-profit hospitals have typically run their enterprises very much on business lines, and they normally have booked profits, although they do not distribute them to any outside owners.

In contrast to Canada and Europe, who tightly control the supply-side of their health sector, Americans have generally[1] freely opened theirs to the seekers of fortune in the belief that the transfer of GNP the providers of care can extract from the rest of society can easily be controlled through the demand side of the sector--primarily by forcing patients to behave like regular consumers. Figure 3 illustrates that so-called "market approach" to health care in its purest form.

[Figure 3]

The traditional instrument of demand-side cost-control in the United States has been cost-sharing by patients. As is shown in Table 2, *on average*, American patients are not nearly as well insured as is sometimes supposed--not even in the heyday of the Great Society--although there is a wide dispersion around this average. Some Americans have no

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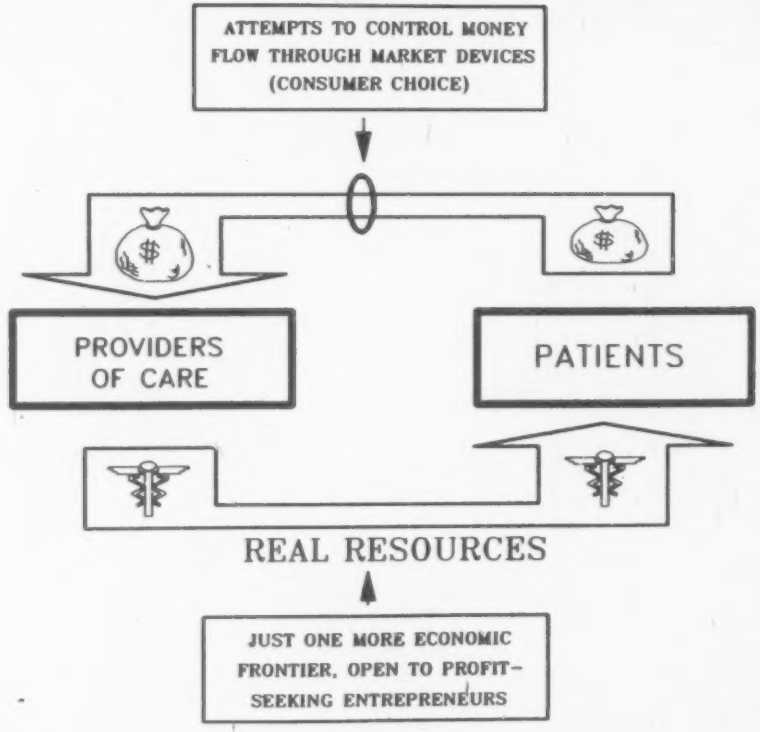
[1] As already noted, some States in the U.S. do control certain segments of their health sector through formal planning--for example, through so-called Certificates-of-Need for hospital beds or hospital-based high-tech equipment. In fact, however, these strictures have generally been of limited effectiveness. Where hospitals have been prohibited from acquiring certain high-tech equipment, for example, physicians have nevertheless been able to acquire it and to operate it in close proximity to the hospital.

FIGURE 3

THE AMERICAN HEALTH-CARE SECTOR


ATTEMPTS TO CONTROL MONEY FLOW THROUGH MARKET DEVICES (CONSUMER CHOICE)
PROVIDERS OF CARE
PATIENTS
REAL RESOURCES
JUST ONE MORE ECONOMIC FRONTIER, OPEN TO PROFIT-SEEKING ENTREPRENEURS

health insurance at all, others have very shallow insurance, and some receive from their employers relative generous coverage that approximates the comprehensive, first-dollar coverage available to Canadians and Europeans. Typical among the latter insured are unionized workers in the Northern rust belt.

[Table 2]

Even the relatively high degree of cost sharing by American patients, however, has not appeared to be able to constrain the growth of national health-care expenditures. As Table 1 above suggests, perhaps that particular donkey is just too weak to carry much of a cost-containment load. For that reason, additional forms of demand-side controls have been deployed in recent years, to wit, (1) ex post utilization control, (2) prospective and concurrent utilization review by third party payers (otherwise known as "managed care"), and (3) the so-called Preferred Provider Organizations (PPOs). These PPOs are networks of fee-for-service providers who have agreed to grant large third-party payers price discounts in return for insurance contracts that steer the insured toward these "preferred" providers through specially tailored forms of cost sharing.

A uniquely American form of cost-control, aimed more at the supply-side of the health-care market, is the Health Maintenance Organization (HMO). Basically, the HMO is an insurance contract under which a network of providers is pre-paid an annual lump-sum capitation per insured, in return for the obligation to furnish the insured all medically necessary care during the contract period. The contract is designed to make providers hold to the medically necessary minimum their use of resources in treating patients. Usually, the HMO contract leads to lower rates of hospitalization, other things being equal, and to relatively lower average per-capita health costs. Their drawback, in the eyes of patients, is that they limit choice among providers, and that they may under-serve patients.

II. THE ECONOMIC FOOTPRINTS OF THESE APPROACHES

It is generally agreed, both here and abroad, that the American, entrepreneurial approach to health care has begotten one of the most luxurious, dynamic, clinically and organizationally innovative, and technically sophisticated health systems in the world. At its best, that system has few rivals anywhere, although many health systems abroad also do have facets of genuine excellence.

A. The Cost of Health Care

Unfortunately, but perfectly predictably, the open-ended American health system is plagued by perennial excess capacity in most parts of the country, and by large and rapidly

TABLE 2

DIRECT OUT OF POCKET EXPENDITURES FOR HEALTH CARE

UNITED STATES, 1977 AND 1987

TYPE OF SERVICE	PERCENTAGE PAID OUT OF POCKET 1977	1987
Physician Services	34%	26%
Ambulatory Physician Care only[a]	59%	N.A.
Hospital Services	8%	10%
Dental Care	73%	61%
Drugs and Medical Sundries	83%	75%
Nursing Home Care	43%	49%
TOTAL PERSONAL HEALTH CARE	31%	28%

[a] Data from the National Medical Expenditure Survey (NMCES), 1977.

SOURCE: Health Care Financing Administration

growing costs. With the exception of New York City--where capacity has been tightly controlled through health planning--the average hospital occupancy-ratio in the United States is now in the mid 60%. It is below 50% in many regions. American physicians, for their part, have for years deplored a growing physician surplus.

This enormous capacity and excess capacity comes at a stiff price. As is shown in Table 3 and Figure 4 below, no other country now operates as expensive a health system as does the United States, and therein lies a major ethical problem:

> *So expensive has American health care become that the nation's middle-and upper-income classes now seem increasingly unwilling to share the blessings of their health system with their millions of low-income, uninsured fellow citizens. The gentleness and kindness for which Americans had come to be known after World War II has, thus, literally been priced out of the nation's soul. By international standards, American health policy towards the poor--particularly towards poor children--now appears rather callous.*

[Table 3, Figure 4]

B. The Uninsured

At this time, some 35 million Americans, about three quarters of them full-time employees and their dependents, and about one third of them children, have no health insurance coverage of any form. Most of these American families have incomes below $20,000 per year, yet for such families, if they are healthy, an individually purchased commercial insurance policy with considerable cost sharing would now cost anywhere between $ 3,000 to $ 4,000 per year, and some insurance companies have ceased to offer such policies even at these prices because they are unprofitable. If such families have chronically ill members, however, a private health-insurance policy may not be available to them at all.

Such enormous gaps in health-insurance coverage are not known anywhere else in the industrialized world. As noted above, without exception, the other member-nations in the Organization for Economic Development (OECD) offer their citizenry *universal* health-insurance coverage for a comprehensive set of health services and supplies, typically including dental care and prescription drugs (with the exception of Canada, where these items are covered only for low-income families).

Traditionally, the American health system has dealt with the uninsured thus: for mild to semi-serious illness, care to the uninsured has been effectively rationed on the basis of price and ability to pay. For critically serious illness, however, care was generally made available through the emergency rooms of hospitals who then shifted the cost of that

TABLE 3

Total Health Expenditure As A Percentage Of Gross Domestic Product

	1960	1965	1970	1975	1980	1985	1986	1987
Australia	4.6%	4.9%	5.0%	5.7%	6.5%	7.0%	7.1%	7.1%
Austria	4.6	5.0	5.4	7.3	7.9	8.1	8.3	8.4
Belgium	3.4	3.9	4.0	5.8	6.6	7.2	7.2	7.2
Canada	5.5	6.1	7.2	7.3	7.4	8.4	8.7	8.6
Denmark	3.6	4.8	6.1	6.5	6.8	6.2	6.0	6.0
Finland	3.9	4.9	5.7	6.3	6.5	7.2	7.3	7.4
France	4.2	5.2	5.8	6.8	7.6	8.6	8.7	8.6
Germany	4.7	5.1	5.5	7.8	7.9	8.2	8.1	8.2
Greece	3.2	3.6	4.0	4.1	4.3	4.9	5.3	5.3
Iceland	1.2	2.8	4.3	5.9	6.4	7.3	7.7	7.8
Ireland	4.0	4.4	5.6	7.7	8.5	8.0	7.8	7.4
Italy	3.3	4.0	4.8	5.8	6.8	6.7	6.6	6.9
Japan	2.9	4.3	4.4	5.5	6.4	6.6	6.7	6.8
Luxembourg	–	–	4.1	5.7	6.8	6.7	6.8	7.5
Netherlands	3.9	4.4	6.0	7.7	8.2	8.3	8.3	8.5
New Zealand	4.4	4.5	5.1	6.4	7.2	6.6	6.9	6.9
Norway	3.3	3.9	5.0	6.7	6.6	6.4	7.1	7.5
Portugal	–	–	–	6.4	5.9	7.0	6.6	6.4
Spain	2.3	2.7	4.1	5.1	5.9	6.0	6.1	6.0
Sweden	4.7	5.6	7.2	8.0	9.5	9.4	9.1	9.0
Switzerland	3.3	3.8	5.2	7.0	7.3	7.7	7.6	7.7
Turkey	–	–	–	–	–	–	3.6	3.5
United Kingdom	3.9	4.1	4.5	5.5	5.8	6.0	6.1	6.1
United States	5.2	6.0	7.4	8.4	9.2	10.6	10.9	11.2
Mean	3.8	4.5	5.3	6.5	7.0	7.4	7.3 (7.4)[a]	7.3 (7.5)[a]

Source: Organization for Economic Cooperation and Development, Health Data Bank.
[a] Mean excluding Turkey.

FIGURE 4

Anatole Kaletsky on US employers' change of attitude to health insurance

Why every Chrysler has a $700 health bill

"I NEVER thought I would be in favour of a government health policy, but there are things the government must do. We have to spread the burden."

If Mr Robert Mercer, the former chairman of Goodyear Tire, had made this remark 10 years ago, his fellow industrialists would probably have concluded that he himself was in need of a rest cure. The "socialised" health services of Britain and Canada had always figured prominently in the political demonology of the US business community. It was simply unthinkable for businessmen to call for greater government involvement in what was, after all, the country's biggest industry.

In the last few years, however, the rising cost of medicine has turned into a critical issue for many American businesses. According to the Bureau of Labour Statistics, approximately 90 per cent of full-time workers in companies with more than 100 employees are covered by corporate health insurance plans. Private employers pay for about a quarter of the country's $355bn in medical costs. In the last two decades, provision of medical insurance has steadily extended from Fortune 500 companies to relatively small employers, so that a survey of 9,000 small companies conducted in January by the National Association of Manufacturers found businessmen citing health costs more than any other issue as the "greatest threat to their economic vitality and ability to compete."

It is largely because of health benefits that US labour costs are rising at an uncomfortable 6 per cent annually, despite moderate pay settlements that have kept the growth of average earnings to only 4 per cent. Yet while businessmen obviously prefer a private system, talk of "national approaches" to medicine is becoming commonplace in boardrooms from Detroit and Akron to Hollywood and even Wall Street.

The latest reminder of the corporate medical crisis was a strike against four of the seven regional telephone companies which at its peak in mid-August involved 260,000 employees. The dispute held the rapt attention of the business community, because health, rather than pay, has been the main issue.

The Bell telephone system had long prided itself on providing its employees with the best medical package in American business. But with average health insurance premiums rising by 10 to 15 per cent a year over the last decade, the telephone companies decided that they had had enough. In June, AT&T tried to force its employees to pick up part of its $1bn annual medical bill by paying 20 per cent of their health costs up to a limit of $1,000 a year. The company withdrew in the face of a strike threat, but it achieved an unexpectedly modest pay settlement in exchange.

Last month, some of the Baby Bells went where their erstwhile parent feared to tread. Nynex, the company which serves New York and New England, decided to make health costs the central issue in its collective bargaining. Even with the concessions it was seeking, Nynex said that its medical bills would grow by 68 per cent to $3,500 per employee over the next three years. The unions, however, have been equally immovable. Defence of medical benefits has proved far more effective in rallying the members than demands for higher pay.

The US now spends almost 12 per cent of its GNP on health, up from 8.1 per cent in 1981. This represents a crushing burden on the economy in absolute terms; the sum is equal to the nation's spending on education and defence combined. It also puts American businesses, which pay about 35 per cent of the nation's medical bills, at a huge disadvantage against foreign competitors. Canada spends only 8.6 per cent of its GNP on health. The figures for Europe and Japan are even lower.

Chrysler has pointed out that for every vehicle it builds in the US, it spends $700 on employee health care. The comparable figures for car manufacturers in Canada and Japan are $233 and $246, the company estimates. Worse, Chrysler's workforce has shrunk markedly in recent years, while the number of retired workers protected by its health schemes continues to rise. As a result, the company's health costs amount to almost $6,000 for every worker it employs. Meanwhile, Chrysler's Japanese competitors are able to start new plants in the US employing only young workers and carrying no burdens for past generations of retirees. So the cost of health care hobbles the company with a big and growing competitive disadvantage even against Japanese plants on US soil.

Not surprisingly, Chrysler's outspoken chairman, Mr Lee Iacocca, has been America's most vocal critic of the present system of medical financing, going so far as to suggest a Canadian-style system of nationalised health insurance.

Less flamboyant business leaders have also moved, albeit cautiously, in this direction. Ford is currently conducting an extensive study of business attitudes to health care in preparation for a major statement on the subject. The basic thrust of its approach is already clear. The country needs "a national strategy," because the problem of private medical costs "is larger than any one company," a senior Ford executive says.

Bethlehem Steel has actually committed itself to lobbying for a "national health policy" in its recently negotiated employment contract with the United Steelworkers.

Other companies, including American Airlines and Baxter International, have gone further, backing a seemingly revolutionary bill drafted two years ago by Senator Edward Kennedy. The bill would require all employers to provide health insurance to their full-time employees.

A few years ago, the idea might have been greeted with alarm. Today, the Kennedy bill enjoys "quite a lot of support," according to Ms Sharon Canner of the National Association of Manufacturers (NAM).

Lee Iacocca has gone so far as to suggest a Canadian-style system of nationalised health insurance

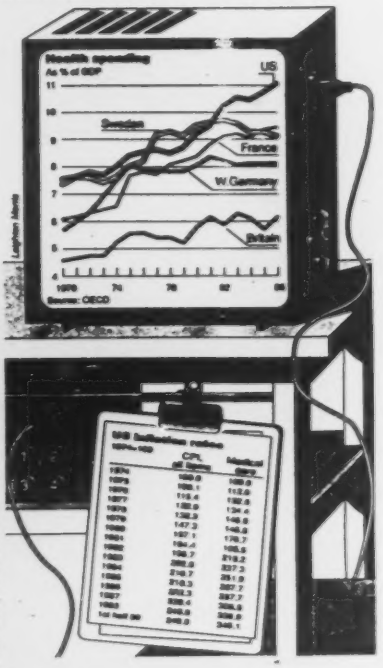
The interest in some kind of legislation stems partly from sheer exasperation. "We simply won't be able to avoid discussion of a national health insurance system in the next few years," says Mr Warren Billings, head of employee benefits at AT&T, although he personally deprecates the idea. "We could get national insurance out of frustration. Employee benefit directors have tried everything to get a handle on cost problems. Some of us are finally throwing up our hands and saying let the government do the job. I'm not, but give me another year or so."

According to Ms Canner, there are better reasons for why corporate America is looking at national approaches to health. One is that companies end up footing the bill for millions of Americans who fall through the cracks of the US health system. About 37m people are covered neither by private health insurance nor the government-funded Medicare and Medicaid programmes, which cater for the elderly and the very poor. Few are ultimately denied treatment in emergencies. Instead, the costs of treating them are added to the hospitals' overheads and passed on to private patients and their insurers. Last year, the hospital industry's total "uncompensated care costs" came to about $40bn. This may have added up to 10 per cent to employers' hospital bills.

An even bigger financial problem for private employers has been the Federal government's attempts to control its own Medicare and Medicaid costs, which account for 40 per cent of US health spending. Government payments for numerous routine procedures have been reduced sharply since 1981 by classifying treatments into "Diagnostic Review Groups," each of which is subject to a cash limit. But instead of cutting their expenses in line with lower government payments, hospitals have gradually made good the shortfalls by raising their charges to patients who are privately insured. A recent NAM survey found that its members' insurance costs had risen by 20 per cent last year, partly because of this by-product of government austerity.

According to Dr Wendy Gray, a researcher at the Conference Board, another big business organisation, the Medicare-Medicaid problems have been just one example of an exasperating general law of medical inflation. "It is like squeezing a balloon; each time you clamp down on one trouble spot another bulges out of control."

She cites another example of this principle. When many insurance companies started requiring second opinions before approving surgery, their costs increased because most second opinions were confirming. "Physicians rely heavily on their colleagues for referrals," Dr Gray notes.



There seems to be a fundamental problem at the root of all these disappointments. "The trouble is that American medicine is based on a tradition of professional entrepreneurship, not public service," Professor Alain Enthoven of Stanford Business Schools wrote recently in a widely discussed article in the New York Times.

When medicine is a business, treatments are sold as if they were consumer products and hospitals actually stimulate demand for care. Many health experts in the business community conclude that long-term cost reduction may depend on innovations which restrict consumer choice and limit or redirect medical marketing. Three such reforms are widely discussed: shifting the remuneration structure towards preventive medicine; consolidating specialised treatments and costly diagnostic facilities in "centres of excellence" and channelling patients through employer- or insurance-sponsored Health Maintenance Organisations (HMOs) or "Preferred Provider Organisations."

Unfortunately, reforms of this kind are difficult for individual employers or insurers to undertake on their own. Preventive medicine produces benefits only in the very long-term and often looks like a waste of money for individual employers or even insurance companies with mobile workforces and client groups. Centres of excellence are politically unpopular because they demote many smaller community hospitals.

HMOs smack of the British national health system by limiting the patient's choice of doctors and using general practitioners as "gatekeepers" to restrict access to hospitals, specialists and expensive hi-tech treatments. They have been unpopular with unions and employees and have disappointed many of their sponsors with the meagre savings produced. In the context of US medicine, patients subject to HMO restrictions often conclude that they are second-class citizens receiving sub-standard care. This can defeat the purpose of medical insurance, which corporations offer to win their employees' loyalty and raise their morale.

Dr Gray says: "The largest companies have historically prided themselves on providing the best of health benefits to their employees. Many are facing shortages of skilled workers and want to remain competitive at the top of end of the labour market. It is just not politically feasible for them and their insurance companies to take the lead in restricting medical delivery and costs. One way or another the government may have to get more involved."

Additional research by Rinka Nachman.

charity care (including needed inpatient care) to paying patients, notably those insured by the business sector.

Unfortunately, in recent years this source of charity care has begun to dry up as the profit margins of hospitals have come to be squeezed by a combination of excess capacity and downward price pressure on the part of both the public- and private-sector payers. On average, an uninsured, low-income American now receives only about 50% to 60% of the health care received by an identical, regularly insured American.

> *Thus, the myth that, unlike other nations, America does not ration health care is just that, a myth. Americans do ration health care by price and ability to pay, sometimes in rather disturbing ways.*

C. Styles of Rationing

The preceding observation suggests that nations differ from one another not by whether or not they do ration health care--all of them do somehow and to varying degrees--but in their style of rationing.

One style is to limit physical capacity and then to use triage based on medical judgement and the queue to determine the allocation of artificially scare resources among the populace. That style of rationing is sometimes referred to as *implicit rationing*.

The other style is to ration *explicitly* by price and ability to pay. It is the natural by-product of the so-called "market approach" to health care.

Implicit rationing predominates outside the United States. In principle, the approach is thought to allocate health care strictly on the basis of medical *need*, as perceived and ranked by physicians. It is not known whether or not other variables, such as the patient's social status, ultimately do enter the allocation decision as well. For example, one wonders whether a gas station attendant in the United Kingdom has quite the same degree of access to limited resources as does, say, a barrister or university professor who may be able to use social connections in attempts to jump the queue.

As noted, many Americans believe that health-care is not now rationed in the United States. That belief seems warranted for well-insured patients who are covered by traditional, open-ended indemnity insurance, and who are living in areas with excess capacity. For many such patients, there seems to be virtually no limit, other than nature, to the use of real resources in attempts to preserve life or to gain certainty in diagnosis. On the other hand, persons who are less well insured, who are uninsured, or who are covered by managed-care plans (including HMOs) do on occasion experience the withholding of health-care resources strictly for economic reasons. In fact, in a recent cross-national survey, some 7.5 percent of the respondents (the equivalent of 18 million Americans) claimed that they had been denied health

care in the previous year for financial reasons. In Canada and the United Kingdom, much fewer than 1 percent of the respondents made that claim[2].

Remarkably, it seems easier to implement the *implicit*, supply-side rationing practiced in most other countries than it is to use the *explicit* American approach to rationing. In the previously cited survey, Americans appeared much less satisfied with their health-care system now than were Canadians and British respondents reacting to the identical set of questions on the subject. [3]

For some reason, both physicians and patients appear to accept with greater equanimity the verdict that needed capacity is simply not available than they do the verdict that available, idle capacity will not be made available because some budget has run out[4]. Thus, while the American approach to rationing does work after a fashion, it tends to create greater rancor among both patients and physicians than does the *implicit* rationing practiced elsewhere in the world. No one likes to see monetary factors enter medical decisions quite so blatantly at the patient's bedside as *explicit* rationing requires. Yet, a nation bent upon using the market approach to health care ultimately cannot escape those troubling acts.

D. Summary on the Economic Footsteps

To sum up at this point. There appears to be a trade-off in the organization of health care that simply cannot be avoided: it is a trade-off among three distinct desiderata in health care, namely, (1) the freedom granted the providers of health care to organize the production of health care as they see fit and to price their products and services as they see fit, (2) the degree of control over total health care expenditures and (3) the degree of equity attained in the distribution of health care. Figure 5 illustrates this trade-off schematically.

[Figure 5]

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[2] See Robert J. Blendon, "Three Systems: A Comparative Story," *Health Management Quarterly*, Vol. XI, No.1, First Quarter, 1989; pp. 2-10.

[3] *Ibid.*

[4] In this connection, see also the fascinating analyis of this facet of British health care in Henry J. Aaron and William B. Schwartz, *The Painful Prescription*, Washington, D.C., The Brookings Institution, 1984.

FIGURE 5

Competing Objectives in Health Care:
Basic Prototypical Systems That Span The Set Of Actual Systems

—DESIDERATA—

Egalitarian Distribution	Freedom From Government Interference in Pricing and in the Practice of Medicine	Budgetary and Cost Control	Prototypical System
YES	YES	NO	The Health-Care Provider's Dream World
YES	NO	YES	A National Health Insurance System with Fee Schedules and Other Utilization Review. (e.g., Canada, West Germany)
NO	YES	YES	A Price-Competitive Market System

III. THE MOST PROBABLE SCENARIO FOR THE 1990s

For the next three to five years, the American health system is likely to muddle through with the current arrangement of high cost and insecure access, troublesome as that prospect may be. There will be rancor and recriminations all around, as everyone will blame everyone else for the "health-care cost explosion" and for the plight of the uninsured.

The fixed overhead cost of health-care providers will be passed around from payer to payer like an unwanted, hot potato. Similarly, the uninsured indigent will be passed from provider to provider as unwanted hot potatoes as well. Its health sector will not be an untarnished source of pride for Americans.

The political process concerning health care will remain paralyzed in the near future, because no politician can as yet muster the courage to announce that there is no free lunch in health care--that kindness and gentleness toward the poor will cost taxpayers some money. As Time magazine suggested on the cover of its issue of October 23, 1989, at the moment American government is, for all intents and purposes, dead. That is certainly so in health policy.

A. Health Expenditures and the Political Economy of the Hot Potato

National Health Expenditures, about $ 600 billion in 1989, will continue to escalate an annual growth rate of between 10% to 11% in the foreseeable future. That is about 3 percentage points faster than the growth of nominal GNP. Business will continue to underwrite about 30% of that total, government somewhere between 42% and 45%, and patients the rest in the form of cost sharing.

By the year 2000, National Health Expenditures are now estimated to reach $1.5 trillion, or 15% of the GNP. If the growth of health expenditures continued to outrun the growth of GNP by 3 percentage points in the foreseeable future, then close to 20% of the GNP would be going to health care by the year 2020 and close to 50% by the year 2050. Figure 6 illustrates these trends under different assumptions about the differential growth in health expenditures and the GNP.

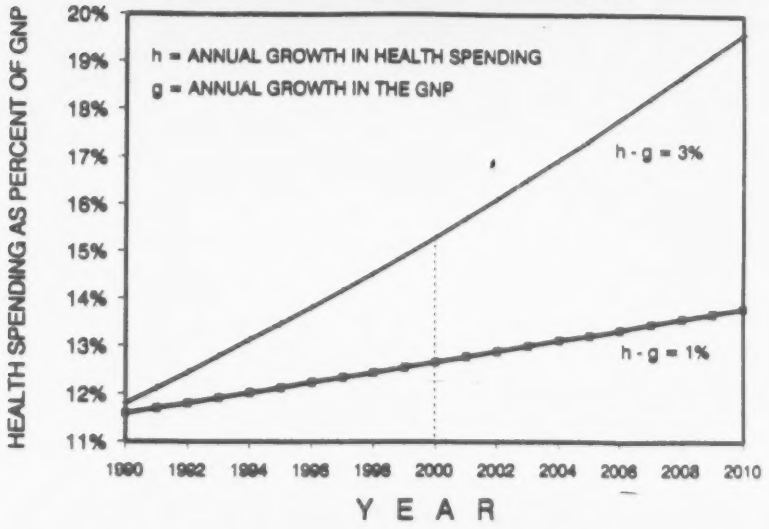
[Figure 6]

The government administered Medicare and Medicaid programs are likely to continue their recent, aggressive cost-containment strategies. Given their market power (about 28% of total national health expenditures), they are apt to succeed in procuring health-care at prices below fully allocated costs, leaving private payers to cover the providers' full overhead and profit. Figure 7 illustrates this procees for a hypothetical hospital that appears to be representative of the bulk of American hospitals today. Both Medicaid and Medicare probably pay the typical hospital less

FIGURE 6

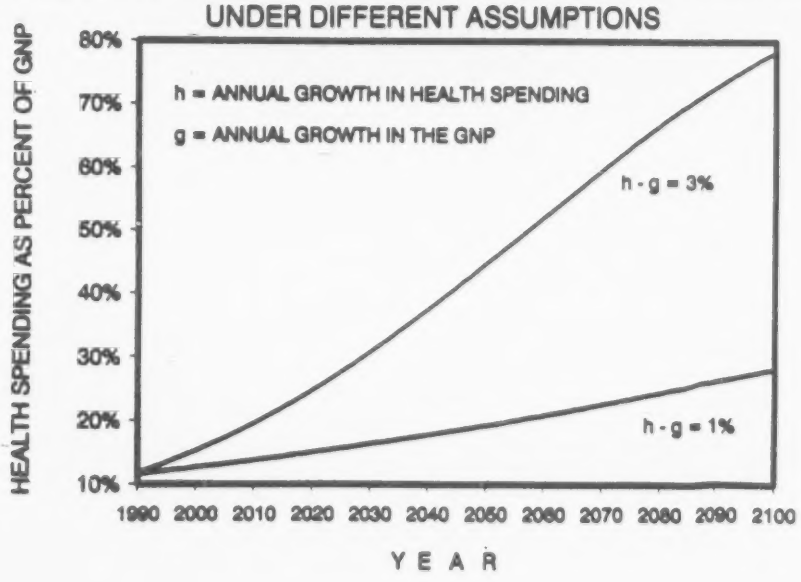
HEALTH CARE AS PERCENT OF THE GNP

UNDER DIFFERENT ASSUMPTIONS



HEALTH CARE AS A PERCENTAGE OF THE GNP

UNDER DIFFERENT ASSUMPTIONS



than fully allocated total cost these days, although more than truly incremental costs. A hospital with excess capacity therefore will find it profitable, at the margin, to accept patients covered by these programs, even if these programs do not should their "fair" share of fixed overhead, although what is "fair" in this context lies in the eyes of the beholder[5]. The uninsured, medically indigent patient typically pays less than fully allocated costs and often even less than incremental costs. Whatever fixed overhead is not covered by Medicaid, Medicare and the indigent, however, must be aborbed by someone. That someone may be the hospital istelf, unless the hospital succeeds in sticking the tab to private insurers, as most of them have been able to do so far. Small business firms and their insurers, in particular, have not been able to resist this cost shift.

[Figure 7]

The providers of health care--and private payers--will lament this exercise of brute market power on the part of the government and describe it as "irresponsible." To be sure, it is a way of raising taxes without forcing the politician to call it such. But, in truth, the voter has left the politician precious few other options.

On the one hand, the voters' lips have consistently read: we do not wish to pay added taxes. It is safe to assume that doctors and hospital executives have overwhelmingly expressed that sentiment at the ballot box by voting for politicians whose lips also read: "no taxes." On the other hand, however, the public sector will face increasing pressure to cut its deficit. Throughout the 1980s, that deficit has been substantially financed with the savings of foreigners. As these savings find attractive new outlets in Eastern Europe and (eventually) in China, the United States can finance its public deficits with foreign savings only if we are prepared to pay real interest rates that are even higher than the historically high rates we have faced during the 1980s. Macro-economic conditions, then, will force the government either to raise taxes or to cut seriously into public spending. Under the circumstances, it is unlikely that the Federal government will treble once again its outlays on Medicare as it did during the 1980s (when Medicare outlays rose from $ 34 billion in 1980 to $ 108 billion in 1990).

Faced with increasing downward pressure on the prices received from the public sector, the providers of health care will seek to extract their unrecovered overhead and profits ever more aggressively the private insurance sector. The business community will argue that the high and growing health-insurance premiums they pay for their employees erodes the ability of American business to compete in the international market place. Although that thesis is highly dubious at the conceptual level[6], it is widely shared nevertheless and will therefore drive the policies of the

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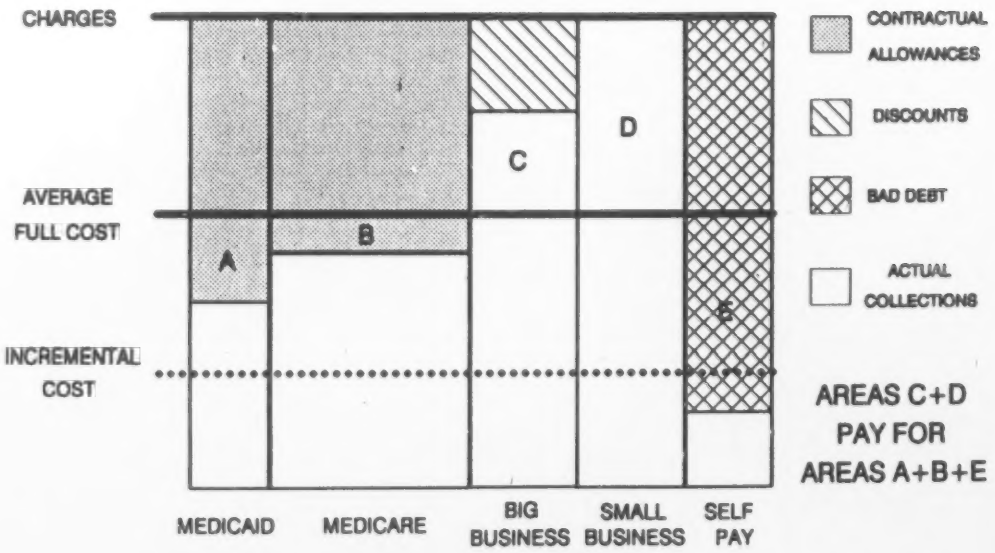
[5] The typical airline, for example, prices its services similarly, without much social opprobrium.

[6] In this connection, see U. E. Reinhardt, "Health Care Spending and American Competitiveness," *Health Affairs*, Winter, 1989; pp. 5-21.

FIGURE 7

HOSPITAL CHARGES, FULL COSTS, INCREMENTAL COSTS AND COLLECTIONS (PER AVERAGE DAY)

(FOR A HYPOTHETICAL AMERICAN HOSPITAL)



SOURCE: Adapted from Lewin/ICF, Inc.

business community. In any event, it is clear that whatever portion of total labor compensation goes to health-benefits cannot be paid out in cash wages--that growing health-insurance premiums eat into the piece of the pie workers have left over for other things. Therein lies the chief imperative for business to control health-care costs.

Large business firms and third-party payers may be able to resist any attempted "cost shift" from the public to the private sector by virtue of their own market muscle (a potential acknowledged in Figure 7 above). Like Medicare and Medicaid, they may even be able to extract from providers some price discounts for themselves. This leaves small third-party payers and business firms to absorb a disproportionate share of the providers' overhead and profits.

Small business firms, whose health care costs per employee have been rising much faster than those of large firms (see Figure 8) are likely to respond to this pressure by refusing to offer their employees health insurance or by cancelling the insurance policies hitherto offered their employees (if the labor market allows them that strategy). Thus, they are likely to dump more Americans into the pool of uninsured, which will put pressure on the hospital sector to which American politicians have traditionally looked as insurers (and tax-collectors) of last resort.

[Figure 8]

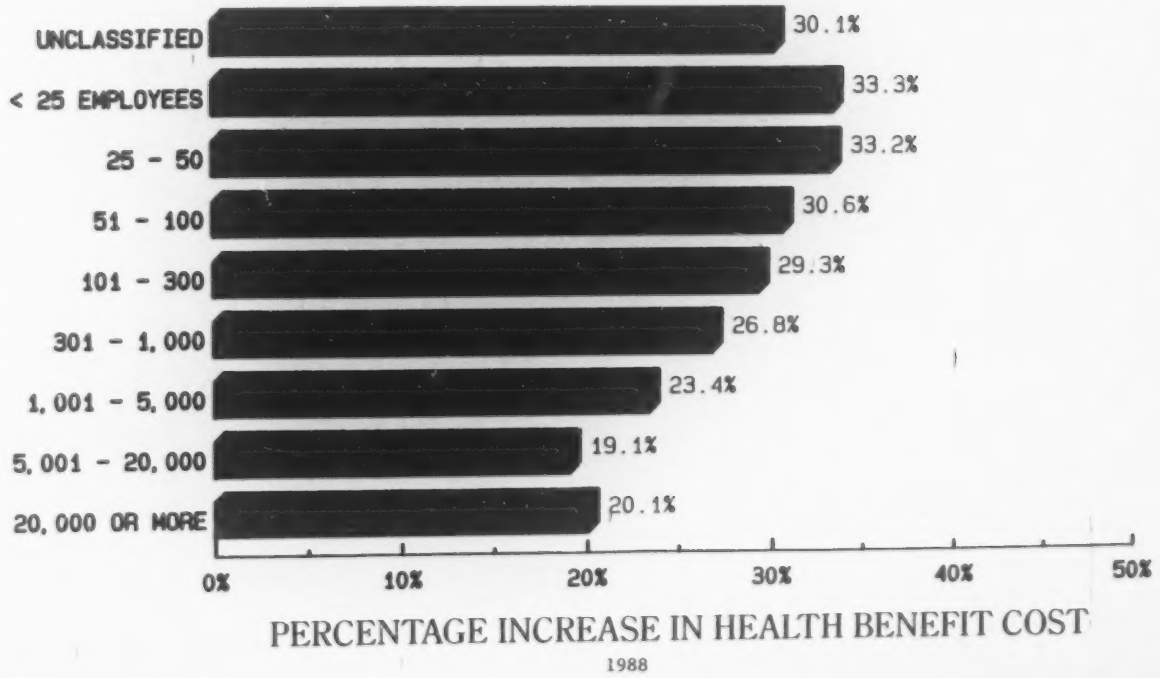
But even if small business firms made every effort to provide their employees with health insurance, the insurance industry may not play along. There is evidence that the industry is now using what is known as "tighter underwriting standards" but may be more aptly described in a New York Times headline "Health Insurers, to Reduce Losses, Blacklist Dozens of Occupations," (by Milt Freudenheim, February 5, 1990). Although one can understand such exclusions from a purely commercial viewpoint, they have an explosive potential from the viewpoint of public policy: the industry literally now seems on a path of self-destruction. Probably its best hope for the long run is survival under very tight public regulation of prices and underwriting standards.

B. Covering the Uninsured

We can expect strong lobbying from doctors, hospitals and the champions of the poor (especially children) to cover the uninsured somehow and at long last. The government is likely to respond to that pressure--and to attempts by business and the insurance industry to dump high-risk employees into the pool of uninsured--by mandating all employers, large and small, to provide their employees with employer-paid private health-insurance coverage. This is a politically appealing way to impose taxes upon the private sector without actually saying so and without having any political accountability for those taxes. Furthermore, it is the strategy preferred by doctors and hospitals who prefer dealing with private insurers rather than with a more powerful public payer.

FIGURE 8

National Association of Manufacturers
Health Care Survey



Source: NAM/Foster Higgins, Meeting the Health Care Crisis (1989)

Although currently a legislative weapon mainly in the arsenal of Democrats, the idea of mandated, employer-paid health insurance is really Richard Nixon's old idea (see his Health Message to the Congress dated February 18, 1971). Republicans--even President Bush--are apt to return to the fold on it, once their feet are pushed closer to the fire by the provider lobbies. My advice would be to market the strategy not as "mandated benefits"--Americans hate the word "mandate--but instead as the **"All American, Private-Public Sector, Judeo-Christian-Islamic-Confucian Health-Care Partnership Act."** Thus it may fly, even in the White House.

Faced with a mandate to purchase health-insurance for their employees, small business firms are likely to cry foul, because they will be forced to pay higher premiums (and prices for care) than will large, self-insured employers. Having been forcibly driven into the arms of hitherto unaccommodating private health insurers, small business-usually the stalwarts of free enterprise--can and probably will add to demands for tighter public regulation of the underwriting practices of private health insurers. There will be calls for a return from *actuarially fair* premiums that reflect the claims experience strictly of the employees of a single firm to *community rated* premiums that reflect the claims experience of an entire community.

Furthermore, small business is likely to demand from the government a parallel mandate for an "all-payer" system. Under such a system all insurance carriers negotiate jointly with providers in a given state (or region) for single price schedules on which all of them pay (as is already the case in New Jersey's hospital system). Once an all-payer health-insurance system is in place, the nation is well its way to stumbling, keister backwards, toward the type of statutory, national health insurance system now operated in West Germany.

Further down the path in the 1990s, Congress is likely to introduce a Kiddiecare program (which would be kind, gentle, and relatively cheap) and ultimately expand Medicaid to sweep up the rest of the unemployed, adult uninsured. Conceivably, these initiatives may precede the election year 1992, although one ought not to bet too many chits on that prospect.

It may also come to pass that, in the mid 1990s, calls will come forth for the means-testing of Medicare through the premium side. It is easy to defend such a policy on both economic and ethical grounds, and one can expect economically hard-pressed Baby Boomers to push for that policy, especially after a narrow segment of well-heeled aged successfully pushed for the abolition of the Catastrophic Medicare Act in late 1989. When the dust of this particular battle between the generations has settled, the well-to-do aged may well pay more for their health care than they would have under the Catastrophic Act.

IV. OTHER POLICY OPTIONS

Figure 9 present a larger menu of alternative approaches to financing and organizing health care. That display distinguishes explicitly between the ownership of the *health insurance* mechanism and the *production* of health care. Almost all health-care systems in the world can be fit into this grid.

[Figure 9]

The health system of the United Kingdom and of Sweden, for example, occupy primarily Box A in Figure 8. One may think of Box A as *socialized medicine*, because the *production* of health care is substantially owned by the government. Clearly, the health system of the U.S. Department of Veterans Affairs resides in Box A as well, as does the bulk of the health-care system for the U.S. armed forces. It has been said that President Eisenhower, staunch opponent to *socialized medicine*, actually spent the bulk of his adult life in just such a system.

The Canadian health system occupies primarily cells A, B and C, as do the bulk of the American Medicare and Medicaid programs. These systems represent *public health insurance*, but not *socialized medicine*.

West Germany's health system is best described by cells D, E and F. It also does not represent *socialized medicine*. As noted above, the American health system is likely to slide towards that sort of arrangement before too long. At this time, the bulk of that system continues to reside in boxes G to L.

Canada's universal, national health-insurance system is now widely offered as a model for the United States. That system, however, has emerged from a parliamentary system with party discipline, and in a nation that, unlike the United States, has a tradition of respect for government and the civil service. It is hard to imagine, however, that the U.S. Congress, which gave us the so-called "Tax Simplification (sic) Act" of 1986, would ever be able to legislate a streamlined, coherent program of the Canadian variety. It is even harder to imagine that this economically heterogenous country, with its inbred disrespect for government and "bureaucrats," could ever operate such a system, even if a coherent program could be legislated.

One could imagine for the United States an honest, two-track health insurance system, in which the government backs up a largely, private health-insurance system with a public, income-tax financed Fail-Safe system. Such a system might be well suited to the American ethos. I had proposed such a system about a year ago in The Wall Street Journal (see attachment overleaf). It ought to be more attractive to the business sector than would be mandated employer-paid health-care benefits. Remarkably, there has been little support for it from the business sector. Perhaps the latter prefers mandated benefits after all, or simply muddling through as usual.

FIGURE 9

ALTERNATIVE MIXES OF HEALTH-INSURANCE AND HEALTH CARE DELIVERY

PRODUCTION AND DELIVERY	COLLECTIVIZED (SOCIALIZED) FINANCING OF HEALTH CARE.			DIRECT FINANCING
		Private Health Insurance[a]		Out of Pocket
	Government Financed Insurance	within a statutory framework	within an unregulated market	by Patients at point of Service
Purely Government Owned	A	D	G	J
Private Not-for-Profit Entities	B	E	H	K
Private For-Profit Entities	C	F	I	L

The Canadian Health System — The West German Health System

[a] Note: Technically, whenever the receipt of health care is paid for by a third party rather than by the recipient at point of service, it is financed out of a collective pool and is thus "socialized" financing. In this sense, private health insurance is just as much "collectivist" or "socialized" as is government-provided health insurance. Both forms of financing destroy the normal workings of a market, because both eliminate the individual benefit-cost calculus that is the sine-qua-non of a proper market.

THE WALL STREET JOURNAL WEDNESDAY, JANUARY 11, 1989

Toward a Fail-Safe Health-Insurance System

By Uwe E. Reinhardt

Critically ill Americans used to be able to get the care they needed from a nearby hospital, even if they could not pay the bill. The hospital would pass on the cost to private health-insurance carriers who, in turn, would pass it on to business through the premiums for employer-paid group health insurance.

This hidden tax system is now coming apart under the forces of a growing number of the uninsured -now an estimated 37 million-, of the ever increasing cost of our ever more sophisticated health care, of the business community's attempts to rein in its health-insurance premiums, and of the public sector's increasingly desperate attempts to control its outlays on Medicare and Medicaid.

Caught at the confluence of these forces, hospitals have begun to deny access even to critically ill patients. Some have even closed their emergency or neonatal-care units, because these are the main points of entry of indigent patients. According to surveys conducted by the Robert Wood Johnson Foundation in 1982 and in 1986, more than one million Americans ineligible for Medicaid are now being denied access to needed health care in any given year for inability to pay.

Political Appeal

Like it or not, the nation will soon be called upon to confront this issue, and replace the crumbling, hidden tax system with another one. Mandating all employers to provide employees health insurance is one option. It would be a payroll tax by another name. A better alternative might be a modified Medicaid system financed explicitly by a combination of income and excise taxes.

Mandating employer-provided health insurance has enormous political appeal, as politicians could coerce fiscal transfers within the private sector without having to account for them through the government's budget. They could pursue desired social goals without letting their lips spell the word "taxes"—no small advantage.

Given this advantage, it is not surprising that mandated benefits enjoy wide support among Americans of all political stripes. The idea first surfaced in President Nixon's Health Message to the Congress of Feb. 18, 1971, and in his subsequent legislative proposal, the Community Health Insurance Partnership. That proposal was shelved as inadequate by Sen. Edward Kennedy and then-Rep. Wilbur Mills. But it has resurfaced during the 1980s, pushed by such leading Democrats as Reps. Pete Stark and Henry Waxman, Massachusetts Gov. Michael Dukakis—and Sen. Kennedy.

Several executives of large U.S. corporations—among them Robert Crandall of American Airlines and Karl Bays of IC Industries -now Whitman Corp.—also have supported employer-mandated benefits in recent testimony before Congress. This is not surprising, since almost all of the cost of health care rendered the indigent gets passed along to big business. Mandated health insurance would shift that cost into the payroll accounts of the firms that employ so many of the uninsured, some of which are the large firms' competitors.

One should not, however, overlook a major shortcoming of mandated employer-paid benefits: They are payroll taxes in disguise, with all of the pernicious economic consequences of such taxes.

Since the vast majority of uninsured workers are in low-paying jobs at small firms, mandated employer-provided health insurance will mean a major percentage increase in these small firms' payroll expenses. Unless they can pass on the added tax through higher prices—which is not to be taken for granted—they are apt to shift much of it back to employees in the form of unemployment or lower wages. If so, employer-mandated health insurance will end up hurting the very people it is intended to help.

A better alternative would be to mandate that coverage upon the individual himself, and then to make sure that affordable health-insurance policies are available to all Americans. As a society, we are bound by the oft-professed pledge not to let a fellow citizen die because he can't afford health care. That noble sentiment can, of course, be exploited by would-be free riders among, say, the 25% of the uninsured who reported family incomes in excess of $30,000 in 1986.

One way to preclude exploitation by free riders might be to fund every American without insurance only a basic, catastrophic Fail-Safe insurance program for which its participants would be charged a progressively rising income tax. People with adequate private insurance coverage would be excused from that tax, as would people below the poverty line.

To control the cost of this program, its benefits should be delivered through qualified managed-care systems, such as preferred provider organizations or health maintenance organizations, under competitively bid contracts with the Fail-Safe system. Further cost control might be achieved by imposing some cost-sharing by patients above the poverty line, up to a maximum out-of-pocket exposure that would vary with income.

The Fail-Safe system could be administered through the state governments, as is the current Medicaid program. Because there is such a high variance in the economic fortunes of individual states, however, the basic benefit package should be defined at the federal level and should be supported through federal cost-sharing, partially with the tax premium collected for that purpose.

A better alternative would be to mandate coverage upon the individual himself, and then to make sure that affordable policies are available to all Americans.

If that tax were made sufficiently progressive, most Americans could be induced to seek cheaper or more comprehensive coverage in the private sector, typically by prevailing upon employers to make such coverage available. Because this nation faces a growing labor shortage, most companies probably would find it in their interest to do so. That circumstance would also most likely prevent many firms now offering group insurance coverage from dumping their employees into the lesser Fail-Safe system.

In 1986, the relatively comprehensive Medicaid program spent an average of $788 per child and about $1,188 per adult in the program. In that year, established HMOs charged annual premiums of $884 for individuals and $2,380 for families. (Those premiums would now be closer to $1,100 and $2,500, respectively.) Most of the 37 million currently uninsured are relatively young; about one-third are children. Had all of them been in the proposed Fail-Safe system in 1986, their total health expenditures might have been somewhere around $40 billion. Of course, the 25% with family incomes in excess of $30,000 would probably be driven into the private sector, so that total program costs might be closer to $30 billion.

Available estimates suggest that somewhere between $8 billion and $12 billion of this total would be from increased demand caused by extending coverage to the now uninsured. The remainder was already spent somehow in 1986, by the uninsured themselves and by other payers, mainly business, to whom the cost of charity care had been shifted.

Financing for the Fail-Safe system would come from a variety of sources. First, the system would collect income taxes from the non-poor it covers. The non-poor would also contribute funds through cost-sharing at point of service. Because the bulk of the non-poor in the Fail-Safe System would have very low incomes, however, it is doubtful that more than $5 billion to $10 billion could be raised from them, depending upon their number. The remainder of the funds would have to be raised through a combination of excise taxes and income taxes, which should come as no surprise. After all, mandated employer benefits, too, would represent additional taxes. Someone has to pay the providers of care to low-income American families if we want those families to have access to at least a basic level of care.

Alcohol, Tobacco and Gasoline

Potential targets for an excise tax would be products that have a deleterious effect on health—among them alcohol, tobacco and gasoline, whose use contributes to ill health through pollution and highway accidents. Finally, all Americans might be asked to bear a small surcharge on their income tax, specifically earmarked for indigent care.

The Fail-Safe system would have several major advantages. First, it would keep the cost of health insurance out of the payroll expense accounts of firms that simply cannot afford it. Second, it would lift the burden of uncompensated care from the shoulders of health-care providers, a burden for which they in no way bear responsibility. Finally, in that it is paid for by specific taxes, it would make more explicit the cost of being one's poor brethren's keeper, which ought to be a good idea in a well-functioning democracy.

Mr. Reinhardt is a professor of political economy at Princeton University.

V. THE ROLE OF THE PHARMACEUTICAL SECTOR IN MODERN HEALTH CARE

A. Expenditures on Pharmaceuticals

The proportion of total national health-care expenditures allocated to pharmaceutical products varies enormously among nations (see Figure 10). In the United States, where prescription drugs are typically not covered by health insurance, only about 7.5 percent of total personal health-care expenditures now go to the category "drugs and sundries." By contrast, in the European nations, where health insurance typically does cover prescription drugs, ratios of between 13 and 20 percent are more common. Japan devotes an even larger proportion of health expenditures on drugs. In 1987, for example, that item accounted for an estimated 38.5 percent of all spending on outpatient care[7]. The estimated figure for Taiwan reaches as high as 50 percent[8].

[Figure 10]

These enormous differences in the use of pharmaceuticals cannot possibly reflect differences in genuine clinical judgement. Instead, they reflect, on the one hand, the degree to which prescription drugs are covered by health insurance and, on the other, the degree to which physicians profit directly from the prescription of drugs. As a general rule, it is reasonable to offer the following propositions:

> *Countries with relatively generous insurance coverage for drugs-e.g., France and West Germany--tend register a high use of physical quantities of drugs per capita, even if prices are tightly controlled (as they are in most European countries). Indeed, whatever such price controls may be, their negative effect on overall expenditures is swamped by greater utilization of physical quantities of pharmaceuticals.*

> *Countries in which physicians themselves sell pharmaceuticals-e.g., Japan and Taiwan--register far higher per-capita utilization*

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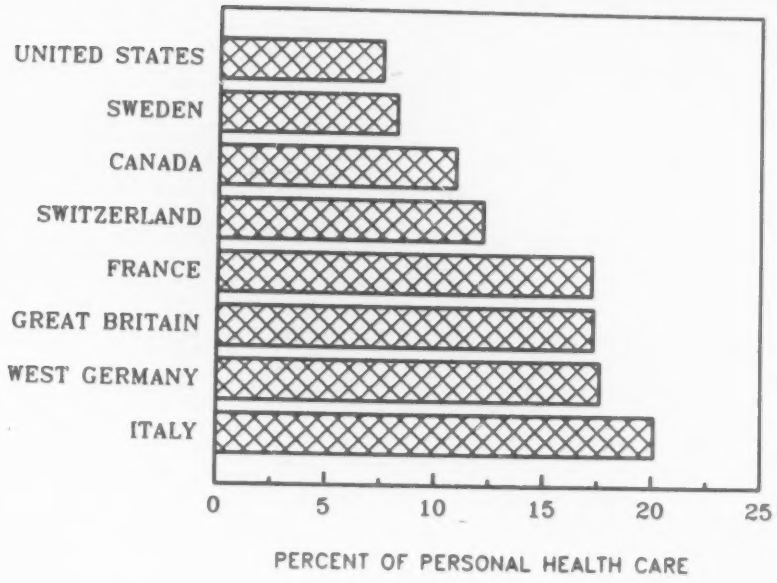
[7] See Naoki Ikegami, "The Japanese Health Care Financing and Delivery System: Its Experiences and Lessons for Other Nations." Mimeographed paper, december 18, 1989; Table14.

[8] Chih-Liang Yuang, "Current System of Health Care Financing and Delivery in the R. O.C. and its Challenge for Future Development." Mimeographed papers, December 18, 1989; p.16.

FIGURE 10

EXPENDITURES ON DRUGS AS A PERCENT OF TOTAL PERSONAL HEALTH-CARE EXPENDITURES 1985



SOURCE: M. Schneider, J.J. Sommer et al. (1989), Table F 4.5.

of pharmaceuticals than do countries in which physicians prescribe drugs and an independent pharmacist sells them. Although physicians usually are loath to concede that economic incentives ever enter their treatment decisions, the data simply suggest otherwise.

As a country's health system develops toward the high-cost, high-tech American model, the share of total health expenditures allocated to pharmaceutical products tends to decline which, of course, does not mean that absolute expenditures will decline as well. They are likely to increase.

B. The Changing American Market for Pharmaceutical Products

Pharmaceutical products span the entire spectrum from pure *private consumption goods* to pure *social goods*. A purely *private consumption good* is one such that its consumption by one person does not affect the happiness of another, either positively or negatively. It is therefore reasonable to insist that those who consume private consumption goods also pay for them with their own resources. A *social good*, on the other hand, is one such that its consumption by one person is also enjoyed by others is society. For example, as a general rule it can be said that, at least in principle, all Americans derive satisfaction from knowing that every American child has access to needed health care. Similarly, society in general benefits from the knowledge that persons with renal failure receive life-saving treatments, including the administration of EPO, and so on.

The consumption of a *social good* need not necessarily be collectively financed. Food and housing, for example, are *social goods* in some sense, and yet we entrust its financing more or less to the individual. Collective financing typically emerges only when the ratio of the cost of the *social good* to the individual's ability to pay rises above tolerable levels--which is frequently the case for, say, AZT, EPO or other high-cost drugs. In many instances, the individual can protect him- or herself against such high costs through private health insurance. When that fails, however, the public sector commonly assumes responsibility for some or all of the cost of the drugs and, in the process, takes a keen interest in their prices. That intrusion is both inevitable and legitimate; but it raises the thorny question to what extent the taxpayers, through such public-health programs, should cover the fixed overhead (including R&D) of the pharmaceutical industry, an issue to which we shall return below.

Aside from the pharmaceuticals sold to inpatient facilities, total expenditures in the American pharmaceutical market have traditionally represented transactions between individual patients and pharmacists So far, there has been little socialized financing in the American pharmaceutical market. Although the individual transactions between patients and pharmacists are not perfect examples of competition in the classical textbook sense, they nevertheless have been relatively

unregulated as to price, and manufacturers have had little difficulty in recovering their R&D outlays through the price mechanism.

This picture has been changing in recent years and is likely to continue to change. During the last decade or so, there has been fairly rapid growth in private insurance coverage for prescription drugs, particularly in the managed care sector (among Health Maintenance Organizations). Furthermore, it can be expected that public sector programs will pay for an increasing share of pharmaceutical consumption in the decades ahead, for at least two reasons.

First, the consumption of pharmaceutical products increases significantly with age. Persons over age 65 tend to consume roughly five times as many pharmaceutical products per year than do persons under age 65, and persons over age 75 close to eight times as many[9]. As the American, and European and Japanese populations age, the worldwide demand for pharmaceutical products is apt to rise. More and more of that demand will be financed with public funds, because the aged everywhere tend to be heavily subsidized in health care. Only in the United States have prescription drugs not been more or less fully covered for the aged; but that is apt to change in the years ahead.

Second, technical progress in the pharmaceutical industry will increasingly enable that industry to develop highly sophisticated, very expensive products aimed at a narrow set of desperately ill patients who, sooner or later, also tend to become the wards of the public sector.

Table 4 below exhibits recent trends in third-party payments for drugs and sundries in the United States. These data include over-the-counter products. To be sure, by international standards third-party coverage of all drugs and sundries is still modest in the United States. In most other countries, excluding Canada, third party payment now covers at least 75 percent of total national expenditures on drugs and sundries. But third-party payment in the United States is growing, which means that in the future more and more of pharmaceutical products will be marketed to at least three clients: (1) the physician treating the patient, (2) the patients themselves, and (3) the third party payers who pay for the prescription.

[Table 4]

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[9] See, for example, Die Private Krankenversicherung: Zahlenbericht 1987/1988 (p.37), the 1987/88 annual report of the private health insurance industry of West Germany, which keeps and regularly publishes accurate statistics on pharmaceutical use by age. Under West German private health insurance, prescriptions drugs are fully covered. In a recent edition of Arzneimittelzeitung dated January 12, 1990 (p.3), a West German pharmaceutical weekly, it was reported that, under West Germany's Statutory Health Insurance System, which also covers prescription drugs, persons aged 80 and over consumed 1,214 "daily doses per year" versus about 107 for persons aged 15 to 29 and 244 for persons aged 50-59. An "average daily doses per year" of 107 signifies that persons aged 15-29 ingest a pharmaceutical an average of 107 days of the year, whatever that pharmaceutical may be, and so on for the other age groups.

TABLE 4

TOTAL NATIONAL EXPENDITURES ON DRUGS AND SUNDRIES

United States, 1980 and 1987

(Billions of Dollars)

TOTAL EXPENDITURES	**$ 19 b**	**$ 34 b**
PERCENTAGE PAID BY:		
Patients directly	80 %	75 %
Private Health Insurance	12 %	14 %
Government, all levels	8 %	11 %
-Medicare	-	-
-Medicaid	7 %	10 %
-Other	1 %	1 %

SOURCE: S. W. Letsch, K. R. Levit and D. R. Waldo, "National Health Expenditures, 1987" Health Care Financing Review, Vol. 10, No. 2, Winter, 1988; Table 9.

Figure 11 illustrates this new market environment schematically. The perception of what is identified in that diagram as private and public *mega-buyers* will increasingly furnish the binding constraint on pharmaceutical prices, and these *mega-buyers* will be swayed primarily by means of convincing benefit-cost analyses. These analyses have been more fully developed in Europe than they have in the United States precisely because *mega-buyers* have dominated the markets there for some time.

[Figure 11]

Finally, an additional and more general constraint upon the pricing policies of pharmaceutical enterprises, traditionally much overlooked by the industry, is likely to emerge from corners of the political arena other than the programs specifically paying for prescription drugs. In the U.S. Congress, for example, the prices of pharmaceutical products have begun to attract some attention simply because these prices have risen rather rapidly for all American consumers in recent years.

C. Pricing Policies in the Pharmaceutical Sector

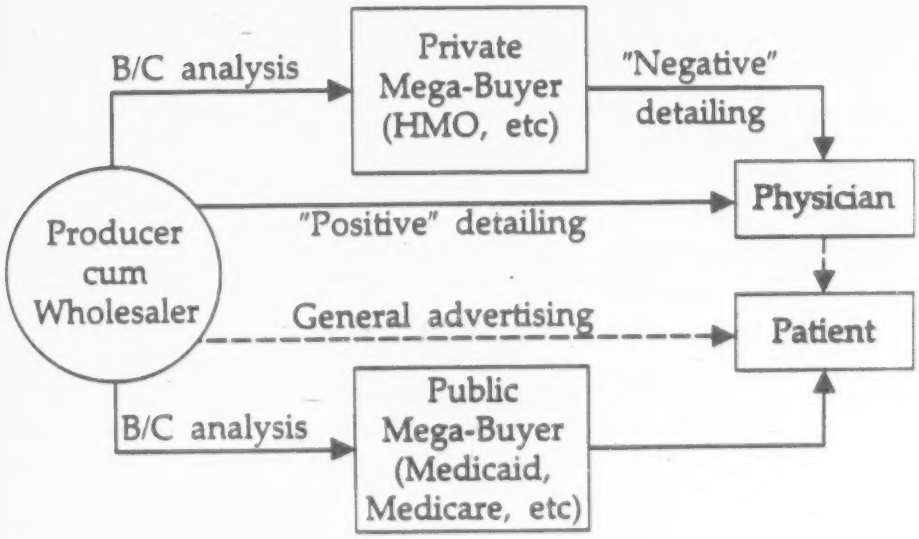
Among the initiated--although not always among the laity--it is well known that the fully-allocated cost of producing a pharmaceutical product represents, for the most part, somewhat arbitrary allocations of fixed costs, among them the research and development efforts of firms, their efforts in marketing and disseminating information about their products, quality control and administrative overhead. The individual product procured by the patient contains only trivial amounts of genuine incremental costs. The bulk of the price represents what accountants call the "contribution margin to overhead and profit," defined as price minus variable costs.

This peculiar cost structure raises a host of thorny problems less prevalent in industries with lower ratios of fixed to total costs.

Entrepreneurial Raiders on the Contribution Margin: As already noted, this contribution margin is huge for pharmaceutical products, and therein lies the first major problem arising out of the pharmaceutical industry's peculiar cost structure: That large contribution margin is an inviting target for private entrepreneurs with sufficient market power to extract discounts from the producer. Producers may resist these raids on their contribution margins for a while; apparently, American producers have done so up to this point. But in a competitive market, any producer with excess capacity will find it profitable to sell product below fully allocated costs, as long as price remains above incremental costs. Under sufficient economic pressure, any such producer is likely to cave in. It is a phenomenon the airlines remember only too well from the early 1980s, and one they have been able to mitigate only through the consolidation of the industry into a few carriers with carefully rigged economic turf.

FIGURE 11

The Emerging Market For Pharmaceuticals



The analogue is likely to drive the pharmaceutical industry into greater consolidation as well.

But the demand side of the market will consolidate as well. Representatives of the pharmaceutical industry in other nations which regulate drug prices tend to look yearningly at the hitherto relatively unregulated American market for pharmaceutical products. They should have a good, second look, as the American market is beginning to consolidate on the demand side in the form of large health-maintenance organizations (HMOs), insurance carriers or so-called repackaging houses that purchase pharmaceuticals in bulk and then repackage them for retail sale by physicians.

Any one of these private bulk-purchasers can establish limited formularies and put them out for competitive bid among competing producers. Some American HMOs now follow this policy, and they couple it with what is called "counter-detailing," that is, education of physicians from within the organization to counter the marketing information aimed at physicians by the detail-men of pharmaceutical producers[10]. Although, so far, the latter have been able to resist many of these raids upon their inviting contribution margins, one must wonder how long they will be able to do so, as market power on the demand side consolidates further and as foreign pharmaceutical producers begin to offer more effective price-competition in the American market than has hitherto been the case.

In the end, it may well be discovered by the industry that a free market in pharmaceutical products, if it permits powerful, private mega-purchasers a free-for-all raid upon the industry's contribution margins, is less comfortable to live with than a regulatory environment in which the regulator or public mega-purchaser must, unlike the private purchaser, pay a good bit of attention to the industry's financial conditions--particularly to the industry's long-run survival as a research enterprise.

Pharmaceutical Prices as "Taxes": For any product whose fixed costs are high relative to true incremental costs, pricing policy in the private sector becomes an exercise analogous to tax policy in the public sector: **in either case, an attempt is made to cover a fixed budget with charges (prices or taxes) upon a revenue base.**

A robust revenue base in this context is one that does not shrink substantially or move away entirely when it is hit by a price or tax. Such a base represents either items that are trivial in the budget of those being charged (e.g., salt, or aspirin, in a private household) or, alternatively, items that are a dire necessity whose consumption cannot be avoided even at high prices.

For such products, there arises the following ethically charged question: Is it fair to levy upon persons who desperately need a pharmaceutical product relatively high

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[10] See, for example, "Is America losing its freedom to choose?" in Drug Topics, September 5, 1988; pp.38-46.

overhead charges, because that particular revenue base is "robust" in the sense that such patients cannot resist high prices? Most societies, once they have attained a certain degree of economic and social development, answer this question firmly in the negative. As already noted, they treat such products as *social goods* and socialize the financing of their consumption--even in the United States. But socialization of that financing inevitably makes the price policy for such products an intensely political matter. To pretend that there exist for such products--e.g., AZT for AIDS patients or EPO for patients with renal failure--a "proper" "free-market" price is pipe-dreaming, pure and simple.

One could take one of two extreme approaches to determining the prices of socialized pharmaceutical products in the political market.

On the one hand, manufacturers could set desired prices for their products, including the indirect overhead to be recovered via these products, and then offer the products to the public sector on a take-it-or-leave-it basis. When "leaving it" implies the death or intense suffering of patients, however, neither the manufacturer nor the government would be likely to appreciate the political heat such a blunt posture might beget.

On the other hand, the government could announce in advance roughly how much per patient per year it would be willing to pay for a yet-to-be-developed product that meets certain specifications (as is done, analogously, in the defense procurement system), and then let pharmaceutical industry try to experiment competitively with meeting these specifications within the announced maximum-price constraint. That policy might make economic sense from the viewpoint of manufacturers, but it would force politicians to reveal their monetary valuation of human life-years or of human suffering explicitly. That posture, too, would be likely to beget more political heat than the normal politician could withstand.

Because either extreme is so inherently troublesome, the actual setting of prices for such *social-good* pharmaceutical products will in all likelihood always remain an ad-hoc affair, replete with strategic posturing, brow-beating and spirited public-relation campaigns. Third-party payers who pay for pharmaceutical products can be expected to train their search-lights squarely onto the industry's cost structure in ways unfamiliar to the industry so far. A particularly target is likely to be the industry's outlays on zero-sum-game marketing. It is a portent the industry should read carefully.

"Marketing" in the emerging context takes on a completely different hue. It is unlikely to be well executed by persons who spend their time bemoaning the inexorable erosion of the traditional market for pharmaceutical products and who believe that their industry can be protected by government-bashing. It requires the special skills of new, politically savvy and politically sensitive "detail- men and -women," who can grasp the perspectives of the politicians and bureaucrats who are charged by the citizenry with guarding the public treasury. It requires persons who are comfortable with a pragmatic policy of muddling through in politically charged terrain.

Representative HAMILTON. Thank you very much, Mr. Reinhardt. Mr. Maher, please proceed.

STATEMENT OF WALTER B. MAHER, DIRECTOR, FEDERAL RELATIONS, HUMAN RESOURCES OFFICE, CHRYSLER CORP.

Mr. MAHER. Mr. Chairman, Chrysler appreciates very much this opportunity to be here this morning to discuss the impact of health costs on our country's competitiveness.

Let me add in response to what Mr. Reinhardt just said, I never had the privilege of meeting Walter Chrysler, but I can assure you the last thing on his mind when he started the company was the design of a medical PPO or HMO to put employees in. Walter Chrysler was interested in building a good car and a good truck and, hopefully, getting the business of the American consumer. It is only the result of this nation's unwillingness to follow the European model in terms of having some coordinated health structure that got the business community involved in financing health care for America's workers.

It was Franklin Roosevelt and all of the progressive programs he put forward—health care was not one of them—and the reason was let's see if we can have a pluralistic system. Unfortunately, as my comments will get to, we do have a pluralistic system, but, however, it is uncoordinated.

If health costs are irrelevant to U.S. business, as one might extrapolate from Mr. Reinhardt's total compensation theory, then a whole lot of employers, large and small, unionized or not, from all corners of this country are wasting an enormous amount of money engaged in what Mr. Reinhardt calls wailing and hand wringing.

And I must say, if my friend Mr. Reinhardt will permit, if health costs are irrelevant to this nation's economy, then the tuition that Princeton students are paying are being inappropriately increased to support the James Madison Chair of Political Economy my friend on my right occupies.

Not being an economist, my perspective on this has to revert to some basics. If two companies are competing in a price-sensitive market, both requiring the same raw materials and a key raw material, for reasons not wholly within the control of the company, is considerably more expensive for one of the competitors, I would contend that company has a competitive disadvantage.

True, the disadvantaged competitor could dispatch its scientists to invent a lower cost substitute material and hope eventually to level the playing field. However, until that happy day arrives, one competitor has a big problem.

The disadvantaged competitor could try diluting the quality of its product, reducing costs in the process to compensate. That may work short term, but eventually consumers would discern the difference and shun the product.

Depending on the size of the price disadvantage, the competitor may try to improve productivity to compensate. This would work short term, but eventually the other competitor would likely adopt the same productivity measures.

Further, all businesses should seek to be as productive as possible on a continuing basis, and such savings should inure to the ben-

efit of consumers, employees, and the business owners and not be used to subsidize waste.

Finally, if the firm involved could succeed in reducing wages regularly to accommodate the disadvantage and this phenomenon impacted all domestic employers, then the firm should pray for a robust export market, for eventually U.S. consumers would not be able to afford to buy what they have built.

Recent labor unrest in America relative to the health cost issue attests to the broad frustration surrounding this matter, and citizen expectations of a broader, more substantive response from their employers and their Government than a simple cost shift.

President Reagan's Commission on Industrial Competitiveness defined competitiveness as the degree to which a nation under free and fair market conditions can produce goods and services that meet the test of international markets while simultaneously expanding or maintaining the real incomes of its citizens. I submit that Mr. Reinhardt never addresses this latter issue. Cutting wastes, benefits, dividends, and profits in order to keep prices from rising will not make the U.S. competitive. If all U.S. workers agreed to work for Third World wages and benefits, then we could very quickly convert our trade deficit into a surplus. But this would not mean that U.S. firms were competitive, and this is not, I hope, the type of society we are striving to create.

Further, health cost is not the only public policy issue artificially driving up our costs. American competitiveness is not rising or falling on the health policy issue. For example, our enormous debt as a nation raises the cost of capital to American companies. The cost of capital in Japan is significantly lower than it is in the United States.

Professor Reinhardt has earlier written this, which I think is very apt for this hearing: "For better or for worse, our health care system is designed to render patients and third-party payers relatively impotent in the market for health services. This then vastly enhances the GNP share that providers can receive, not only per year but also per unit of health care delivered. Where European and Canadian providers have for years chafed under the yoke of a monopsonistic health care market, leaving the rest of society luxuriating in relatively low health care expenditures, their American counterparts have been able to luxuriate in a system over whose financial flows they have wielded substantial control under the principle of divide-and-rule, leaving the rest of American society to chafe under the yoke of seemingly uncontrollable health care expenditures."

With respect to the auto business, German and Japanese auto manufacturers are doing the luxuriating, while their American countersparts have been left to this chafing. It is important to understand that in both Germany and Japan employers are significant contributors to their nations' health care system. They do have a pluralistic system; however, it is coordinated, and as a result, overall health system costs in those countries are significantly less than in America.

And I have this data in my prepared statement, Mr. Chairman. It shows that this problem is getting worse. Health spending per capita in America in 1980 exceeded German spending by 55 percent

and Japan's by 109 percent. The most recent data for 1987 indicate that health spending per capita in America exceeds the German rate by 88 percent and the Japanese rate by 124 percent.

Now, this cost difference contributes to foreign automakers having a $300 to $500 per car advantage over us due to health costs alone. And we are likewise at a disadvantage compared with new foreign-owned firms locating in America which, while offering similar benefit plans, employ a much younger work force and are a generation away from their first retiree.

Now, the strategies that business are using to control costs are a combination of cost shifting to employees, managed-care efforts with varying levels of success, and other efforts to reduce labor costs by the automating or outsourcing of jobs.

There are many health system reform proposals on the table. The most recent Pepper Commission recommendations addressed not only the access-to-care problem but the cost problem. It is quite vital that they do that because these two issues are inextricably linked. There is no nation that has embarked on a program to provide all citizens access to health care without concurrently adopting a strong, coordinated plan to help assure the control of costs.

The Pepper Commission recommendations had some very good things; namely, the expansion of public program coverage to the poor and increasing Medicaid reimbursement for doctors and hospitals. It is vital that all publicly financed health programs should be operated so as not to cause providers to shift costs to payers. And it is a must if we are going to go forward with a public-private partnership in addressing the health care cost access issue.

We are convinced that, to accomplish overall health system reform--you have heard me use the term "coordination"—we cannot have the private sector doing its own thing, pitting large buyers against small ones and permit the public sector, which is the only one empowered to pass laws and shift costs, to operate its health plans without regard to their impact on private sector payers.

Coordination is required, and it is important to realize that coordination and pluralism are not mutually inconsistent.

Relative to financing, we believe the cost of health care should be spread more equitably among individuals, business, and Government. Exporters to America should help finance our country's social programs as U.S. firms do when they export and pay VAT's. Health plan beneficiaries should have a financial stake in the operation of their health plan. And we also believe that participation by all employers in some way in financing the system is an essential ingredient to the solution.

But this problem that Mr. Reinhardt mentioned about the employer mandates is a very vital one, and we have to find a way to address the legitimate concerns of the very small business person because if the concerns of these small employers cannot be satisfied because of legitimate worries about tying health coverage to employment and the resulting impact on hiring and production costs, and as a result the health system reform needed by all employers is stalemated, then we believe it would be appropriate to reconsider the tie to employment and find some alternative way for all businesses to help contribute to the support of the U.S. health system.

In conclusion, Mr. Chairman, too often in the health system reform debate, people are riveted on whether or not we should maximize the employment-based system for the working population as opposed to some other option or whether we should have a rate-setting system instead of a market price system, rather than focusing on what happens to this health system if indeed we do continue with an employment-based system and a public system for the poor and the elderly and the public system is prohibited from cost shifting to the private sector, as it should be. If Government, the largest buyer, agrees to pay in a way which does not shift costs to the private sector, this suggests that a large private firm should not be able to pay providers in a way which leads to cost shifting to smaller ones, which I believe is a proper hypothesis.

Further, if Government agrees to pay its fair share of the capital and medical education expense, then I would hope you would see developed a process whereby Government assures itself that any expenditure of taxpayer funds for supply-side expansion was appropriate. Unlike prior health planning strategies, however, Government would now be compelled to address this issue from the standpoint of aggregate fiscal limitations, since it would no longer have the luxury of cost shifting.

All of this could have a compelling, positive impact on the private sector. However, it will not—and I agree with Professor Reinhardt, if the private sector payers insist on paying what the traffic will bear, tolerate inefficient practice styles, fund unnecessary capacity, and fail to protect plan beneficiaries from these and other excesses.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Maher follows:]

PREPARED STATEMENT OF WALTER B. MAHER

Chrysler Corporation appreciates this opportunity to appear before the Joint Economic Committee to discuss how health care costs affect our country's competitiveness. We strongly believe the cost of health care is eroding standards of living and sapping industrial strength from virtually all segments of American society. Accordingly, we disagree with the concept, adopted by Uwe Reinhardt of Princeton, that high health care costs per se are not harmful to American business. Reinhardt argues health benefits are merely one element of a compensation package which should be flexible enough to accommodate such problems.

If health costs are irrelevant to U.S. business, as one might extrapolate from Professor Reinhardt's "total compensation" theory, then a whole lot of employers, large and small, unionized and not, from all corners of this country are wasting an enormous amount of effort and money engaged in what Reinhardt calls "hand-wringing" and "wailing."

Not being an economist, my perspective on this issue must revert to some basics. If two companies are competing in a price-sensitive market, both requiring the same raw materials, and a key raw material, for reasons not wholly within the control of the company, is considerably more expensive for one of the competitors, I would contend that company has a competitive disadvantage. True, the disadvantaged competitor could dispatch its scientists to invent a lower cost, substitute material and hope, eventually, to

level the playing field. However, until that happy day arrives, one competitor has a big problem.

The disadvantaged competitor could try diluting the quality of its product, reducing costs in the process, to compensate. That may work short term, but eventually consumers would discern the difference and shun the product.

Depending on the size of the price disadvantage, the competitor may try to improve productivity to compensate. This would work short term, but eventually the other competitor would likely adopt the same productivity measures. Further, all businesses should seek to be as productive as possible on a continuing basis, and such savings should inure to the benefit of consumers, employees and the business owners, not be used to subsidize waste.

If the firm involved could succeed in reducing wages regularly to accommodate the disadvantage and this phenomenon impacted all domestic employers, then the firms should pray for a robust export market for eventually U.S. consumers would not be able to afford "to buy what they built." Recent labor unrest in America relative to the health cost issue attests to the broad frustration surrounding this matter and citizen expectation of a broader, more substantive response from their employers and their government than a simple cost shift.

There appears to exist a virtual consensus in the country that our health system is substantially flawed and requires a massive overhaul. In earlier works, Reinhardt has correctly determined that the "system has been carefully constructed to prevent the amassing of significant market power on the demand side" which has "become a major contributor to the high cost of American health care" and is "one of the many reasons why health care expenditures in the U.S. have outpaced those in the rest of the industrialized world." He has conceded that the U.S. has "failed to attain either equity or budgetary and cost control" in its health system and that we have created "the most bureaucratic health system anywhere in the industrialized western democracies."

As a result of America's uncoordinated, pluralistic system, Reinhardt has also discerned that:

> "An individual payer - even one as large as a nationwide commercial insurer or General Motors - will therefore always think twice before attempting rigorous cost-control over providers, even if the payers believe they are paying too much for too many services and supporting vast excess capacity in the system.
>
> And therein, of course, lies one reason for this Nation's extraordinarily high health care expenditures. For better or for worse, our health system is designed to render patients and third-party payers relatively impotent in the market for health service. This then vastly enhances the GNP share that providers can receive, not only per year but also per unit of health care delivered. Where European (and Canadian) providers have for years chafed under the yoke of a monopsonistic health care market - leaving the rest of society luxuriating in relatively low health care expenditures - their American

> counterparts have been able to luxuriate in a system over whose financial flows they have wielded substantial control through the principle of "divide and rule" - leaving the rest of American society to chafe under the yoke of seemingly uncontrollable health expenditures."[1]

Well, with respect to the auto business, German and Japanese manufacturers are doing the "luxuriating" while their American counterparts have been left to the "chafing."

In both Germany and Japan, employers are significant contributors to their nations' health systems. However, overall health system costs in those countries are significantly less than in American and, as the table below indicates, the problem is getting worse.

HEALTH SPENDING PER CAPITA

	1980		1987	
	$	% U.S. Higher	$	% U.S. Higher
United States	$1,089	-	$2,051	-
Germany	$ 704	55%	$1,093	88%
Japan	$ 522	109%	$ 915	124%

Source: Organization for Economic Cooperation and Development: Health Data File, 1989

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[1] Reinhardt, Uwe E.: Responding to: What Can America Learn from Europeans? Health Care Financing Review, 1989 Annual Supplement.

Chrysler is quite concerned about the competitive damage inherent in the dramatic difference between U.S. and foreign health costs. Seven hundred dollars of the cost of every U.S.-built Chrysler car goes to support the U.S. health system (Exhibit 1). Cost differences described above contribute to foreign automakers having a $300 to $500 per car advantage over us due to health costs alone (Exhibit 2). We are likewise at a disadvantage compared with new foreign-owned firms locating in America which, while offering similar benefit plans, employ a much younger workforce and are a generation away from their first retiree.

The private sector has not ignored this problem. It has been hard at work on the health cost problem for years. In mid-1981, Chrysler established America's first Board of Directors'-level committee devoted exclusively to analyzing Chrysler's health care cost problem and searching for solutions. Since that time, a substantial number of cost management initiatives have been adopted and even more actions are planned. Despite these actions, Chrysler has seen its per capita cost of providing health coverage to employees and retirees increase at an average annual rate of over 8 percent since 1981. While this was substantially better than the average business' experience, it nevertheless represented a rate of increase which exceeded both CPI and GNP growth.

Business is quite limited as to what it can do in response to this problem, other than managing its benefit programs as

effectively as possible. It cannot import a cheaper product from abroad. Those involved in competitive markets (like the fiercely competitive automobile business) cannot raise prices at will to recoup higher health costs. Instead, what results is a classic squeeze on profits. Lower profits reduce the funds which would otherwise be available for investment in research, new products and job creation. Lower profits also result in a reduction of tax revenues for investment by government in infrastructure improvement, including vital areas such as education.

The strategies that appear to be most in use by business are a combination of cost-shifting to employees, managed care efforts with varying levels of success, and other efforts to reduce labor costs by the automating or outsourcing of jobs. We obviously disagree with the suggestion that U.S. firms engaged in international competition could successfully adopt a strategy of reducing workers' pay to compensate for the difference between U.S. and foreign health costs. It should be quite clear that any business adopting a long-term strategy of gradually impoverishing employees to make up for escalating U.S. health costs, just might find it hard to retain employees, not to mention hiring replacements. There are, after all, countless employers in America <u>not</u> engaged in foreign competition. While U.S. firms must compete on price on a worldwide basis, they must compete for labor domestically.

President Reagan's Commission on Industrial Competitiveness defined competitiveness as the "degree to which a nation can, under free and fair market conditions, produce goods and services that meet the test of international markets while simultaneously maintaining or expanding the real incomes of its citizens.[2] Reinhardt never addresses this.

> "Cutting wages, benefits, dividends and profits in order to keep prices from rising will not make the U.S. competitive. If all U.S. workers agreed to work for Third World wages and benefits, then we could very quickly convert our trade deficit into a surplus. But this would not mean that U.S. firms were competitive, and this is not, I hope, the type of society we are striving to create. Higher health costs, whether paid by workers, owners or consumers, are reducing U.S. competitiveness."[3]

Some, including Reinhardt, would deflect attention from the underlying issue: the inherent cost-inflationary faults of the U.S. health care system, by speculating that even if the problem did not exist, American producers may not be able to produce world-class competitive products, and by otherwise citing incorrect data particularly about the sale of Japanese cars in America.

First, let it be clear that Chrysler expects to have to compete fairly for a consumer's business. Further, health care is not the only public policy issue artificially driving up our costs.

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2 President's Commission on Industrial Competitiveness. 1985. Global Competition: The New Reality, vol. I, 6, emphasis added.

3 Rasell, M. Edith: Response to Uwe Reinhardt. To appear in Health Affairs, Summer 1990.

For example, America's enormous debt raises the cost of capital to American companies. The cost of capital in Japan is about 3%. For an American company, it's about 7%.

Reinhardt has incorrectly portrayed the United States as a country which has sheltered its domestic auto producers with "a protective umbrella that has allowed them to raise their own prices (and incomes) in step."[4]

The facts are dramatically otherwise. The U.S. and Canada are the only industrial markets in the world which have unmanaged auto trade with Japan. Japan's share in Western Europe has been relatively flat at about 10%, or about 1/3 of its current penetration of the U.S. market. Japan accounts for 38% of the U.S. trade deficit and 69% of that is in autos. Total vehicle imports in Japan, by contrast, represented 2.5% of their market in 1989, reflecting the protected nature of their market. Imports from the U.S. represented less than .5% of the Japanese car market in 1989 with almost half of that coming from Japanese owned firms located in America. While Chrysler is America's leading car exporter to Europe, it cannot get its foot in the door in Japan.

Relative to big American profits, Big 3 after-tax operating profits as a percent of sales revenue have deteriorated rapidly

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[4] Reinhardt, Uwe E.: Health Care Woes of American Business: Reinhardt Responds. Health Affairs, Spring 1990.

from over 6% in 1984 to about 1% last year. All three companies lost money on their North American business in the fourth quarter of 1989. Needless to say, the loss of auto production and employment is rippling its way through the economy.

On the quality front, quality levels have improved dramatically throughout the industry. The average difference between Big 3 quality levels and Japanese quality levels is now less than one repair per vehicle in a 12 month period.

There are other product advantages inherent in American products. Relative to safety, Chrysler, for example, has more offerings then the Japanese with air bags and anti-lock brakes. Chrysler offers the best power train warranty in the industry, domestic or foreign. Our new A-604 ultradrive is the world's most advanced production transmission.

Relative to prices, Japanese imports have raised their prices 32.7% since September of 1985. During the same time period Chrysler's prices have increased 8.4%. The CPI, over this same period, rose 15.5%.

So much for the protected U.S. auto industry.

Given Chrysler's concerns regarding health care costs and the absence of an overall health policy for our nation, we are

gratified that the Pepper Commission addressed both the high cost of health care in America as well as the large number of uninsured in its recently issued recommendations. These two issues are inextricably linked.

No nation on earth has embarked on a program providing all citizens access to health care without concurrently adopting a strong, coordinated plan to help assure control of costs. This is an extraordinarily important fact, and we urge Congress to keep it constantly in mind as there are many forces at work who will try and convince you that tough cost controls are not possible in America. They are, and they must be.

The Pepper Commission recommendations address many concerns of the business community. The expansion of public program coverage for the poor is long overdue, as is increasing Medicaid reimbursement for doctors and hospitals. All publicly-financed health programs should be operated so as not to cause providers to shift costs to private sector payers. This, I submit, is a must if we are to go forward with a public-private partnership in addressing the health care access/cost issue.

Malpractice litigation reform is likewise an urgent problem requiring immediate attention at the federal level, and we were pleased to see it prominently mentioned in the recommendations.

The Pepper Commission recommendations were much less aggressive than we had hoped for regarding overall health system cost control. As a nation we are currently overspending on health care at the rate of $100 billion per year, almost 40 percent more per capita than the second most expensive country on earth. In addition to those initiatives recommended by the Commission, expenditures for capacity expansion and renewal and for technology development and diffusion merit special attention. Further, the subject of medical education expenditures, particularly if they contribute to a proliferation of specialists and sub-specialists at a time when we need more primary care and family practitioners, requires scrutiny. Finally, establishing a process to help assure aggregate U.S. health expenditures are more consistent with effective medical practice and costs in other leading countries is a concept we believe deserves to be included in any health system reform package.

Chrysler is convinced that to accomplish overall health system reform, satisfying business concerns regarding cost and public concerns regarding access, government must be involved in the solution. We cannot have the private sector doing its own thing, pitting large buyers against small ones, and permit the public sector, the only one empowered to pass laws and shift costs, to operate its health plans without regard to their impact on private sector payers. Coordination is required; and it is important to realize that coordination and pluralism are not mutually

inconsistent. For example, the Health Care Financing Review's 1989 Annual Supplement is devoted to an international comparison of health care financing and delivery systems. It contains interesting insights regarding what different systems can learn from one another and much discussion regarding indications that health care system philosophies are converging. The article by Bengt Jonsson of Sweden's Department of Health and Society best focuses on the deficiencies of the U.S. system, specifically its fragmented, uncoordinated structure:

> "It seems clear that a "free" market cannot solve the basic resource allocation problems in health care: efficiency and equity in health care production and consumption. Public insurance systems, tax subsidies to private insurance, asymmetric information between producers and consumers, and provider monopolies through licensing (doctors) are inherent factors in a health care system that make free competition an ineffective policy; competition has to be "managed.". . . .
>
> The idea of prospective payment lies behind the development of DRGs to classify patients. This system, developed at Yale University, is as close as one can come to what Oscar Lange (1938) called "market socialism." Hospitals compete against a set of predetermined administrative prices. . . . Today, when the era of rapidly expanding health care resources has come to an end, new medical technology is the major dynamic factor in health care. Clearly, future policy will be aimed at control of introduction and diffusion of new medical technology. Medical technology assessment (MTA), based on explicit cost-effectiveness and cost-benefit studies, will certainly have a major role in the development of those policies.
>
> The convergence theory implies that planning will play an increasing role in market economies. Developments in the United States during the 1980s cannot accurately be described as increased health care planning. But they certainly represent an increase in public control over the health care system. This can best be understood by looking at the great attraction HMOs, DRGs, and MTA have

> had for health researchers and policy makers in Europe. These ideas have fit in well with the more comprehensive and planned systems in Europe. They have been seen as a way to increase the role of markets and competition within systems in which traditional planning has proven impotent to adapt to a situation of slower resource growth with continued introduction of new medical technology. . . .
>
> The single most important lesson from the European health care systems during the 1980s concerns the role of central government. . . . Compared with Europe, the U.S. Federal Government seems to have less control over the totality of the system, at the same time that it is more directly involved in detailed regulation of efficacy, safety, and price setting. Leadership and control of global expenditures and decisions regarding the comprehensiveness of the system must come from the center, but planning and management should be left to the regional level. Decentralization can be combined with internal markets and competition among providers. Planning and markets are not necessarily antithetical; they can work together to create better health services."[5]

More specifically relative to the need for coordination between public and private sector payers, federal, state and local government programs account for 40 percent of the health services purchased in America and the percentage is likely to grow. Accordingly, the manner in which such programs are operated, including the prices paid, utilization controls or the absence thereof, and other reimbursement policies, and the populations and services covered or not covered, has the capacity to substantially impact the behavior patterns of health services providers, the prices charged to private sector purchasers, the funds available for capital expansion and medical education programs, and, in

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[5] Jonsson, B.: What Can America Learn from Europeans? Health Care Financing Review, 1989 Annual Supplement.

general, the entire U.S. market for health services . . . the same market from which the private sector must purchase health services.

Further, federal tax policy has contributed significantly to the development and growth of private sector health plans.

Acting effectively in its various capacities as the sponsor of public health programs, as a standard setter and as the developer of tax policy, the Federal Government can help chart the course for a rational health policy for America which is so desperately needed by U.S. businesses and citizens. It can fulfil this role in one of two general ways -- either by establishing the overall ground rules within which public and private sector programs must operate to accomplish our nation's health care objectives. The other way is for government to assume a more dominant role in the administration of the system. We do not see any other solutions at this time which hold promise for success.

Relative to financing, Chrysler believes the cost of health care should be spread more equitably among individuals, business and government. Exporters to the U.S. should help finance our country's social programs as U.S. firms do when they export and pay VATs. Health plan beneficiaries must have a financial stake in the efficient operation of their health plan. We also believe participation by all employers in the financing of health care is an essential ingredient to a solution.

That being said, we do not believe government should mandate participation in a health system that is broken. Government should not mandate any employer into a system without at the same time assuring that employer it was buying into a rationally-priced system and one whose annual cost increases were relatively predictable.

One way to provide such assurance and to accelerate the whole system reform process would be for government, having concurrently addressed the malpractice problem and funded appropriately initiatives to develop and use treatment practice guidelines, to take the steps necessary to assure that the new public program or programs contemplated by the Pepper Commission's recommendations (whether federal or state-administered) be models of efficiency, with built-in spending controls such as expenditure targets or volume performance standards applicable to all services. Any individual or employer should have the unfettered option of buying into such a plan on a community rate basis which should serve to spur the private sector to come up with even better products.

Some may reasonably ask: What assurance is there that government can run an efficient system? I submit it all comes back to a requirement that government be required to pay fairly for services rendered to Medicare and Medicaid beneficiaries in a manner whereby it pays fully for services rendered, including its

fair share for hospital capital and medical education, and not have the latitude to cost shift. Given that starting point, government must then contend with the following facts:

- For the foreseeable future, government will be under fiscal constraints to contain the cost of public health programs and not exacerbate the federal deficit.

- Government, however, under this scenario will be prohibited from realizing its cost objective by shifting costs to the private sector.

- Government, likewise, will be constrained by the political clout of the beneficiary population (notably seniors) from realizing its cost objective by diluting the quality of the public health program.

- Government will also be constrained by the political undesirability of raising taxes as a means of financing an uncontrolled public health plan.

- Accordingly, government will be compelled to run an efficient health plan, one embodying the best managed care techniques available.

If this hypothesis is wrong, then very few, if any, would buy-in to such a plan, choosing instead more efficient private sector plans, and the only complaints Congress would receive would be from taxpayers complaining about the high taxes required to run such a program, rather than the complaints being heard today from the uninsured about a lack of coverage, and from business about cost shifting ... which is as it should be.

Given the above, we submit that providing any person or any employer the option of buying into such a plan should alleviate many concerns about the availability of affordable health coverage.

Further, if offering a certain level of health coverage is to be expected of all employers, then <u>at least as to the cost for such coverage</u> an employer should be neither advantaged or disadvantaged based on employee demographics or the location of a business. Having the opportunity to buy this coverage at no more than a community rate would also help ensure that employers would have no incentive to discriminate against employees on the basis of the number of their dependents or their prior medical history.

A major problem the health system reform debate must contend with is how to address the legitimate concerns of the very small business person. Seventy-five percent of U.S. businesses employ fewer than ten persons. The majority of them do <u>not</u> currently offer health coverage. In the aggregate, 46 percent of U.S.

employers do not offer coverage. While they employ only 15 percent of the nation's workers, they represent an obstacle to universal access if employer-based coverage is to be the chosen financing vehicle.

If the concerns of these employers cannot be satisfied because of legitimate worries about tieing health coverage to employment and the resulting impact on hiring and production costs, and as a result the health system reform needed by all employers is stalemated, then we believe it would be appropriate to reconsider the tie to employment and find some alternative way for all businesses to help contribute to the support of the U.S. health system, e.g., through the tax system.

Too often in the health system reform debate people are riveted on whether or not we should maximize the employment based system for the working population as opposed to some other option, or whether we should have rate-setting instead of "market-prices," rather than focusing on what happens to the health system if indeed we do continue with an employment based system and a public system for the poor and the elderly and the public system is prohibited from cost shifting to the private sector as it should be. If government, the largest buyer, agrees to pay in a way which does not shift costs to the private sector, this suggests that a large, private firm should not be able to pay providers in a way which leads to cost shifting to smaller firms. There would, of course,

still be ample opportunity for local initiatives whereby a business could enter into, for example, risk arrangements with providers or managed car systems so long as these were not a subterfuge for cost shifting.

Further, if government agrees to pay its fair share of capital and medical education expenses, then I would hope you would see developed a process whereby government assures itself that any expenditure of taxpayer funds for supply side expansion was appropriate. Unlike prior health planning strategies, however, government would now be compelled to address this issue from the standpoint of aggregate fiscal limitations, since it would no longer have the luxury of cost shifting.

All of this could have a compelling, positive impact on the private sector. However it will not if private sector payers insist on paying what the traffic will bear, tolerate inefficient practice styles, fund unnecessary capacity and fail to protect plan beneficiaries from these and other excesses.

The causes of our health cost problem are legion, but a factor undoubtedly contributing to most of them is that America's health system per se has never been required by those financing the system to cope with any semblance of a resource limit. Further, health care has not appeared to be the type of good or service where fragmented purchasers, at least up to now, have been able to step in and regain overall control. One reason is that health care,

itself, is big business in America. Reclaiming $100 billion will not be easy. The essence of any business is to grow, not shrink. That philosophy is imbedded within most all the major players comprising our country's health care system. This includes not only doctors and hospitals, but others, such as pharmaceutical and medical equipment manufacturers. Health care is mass marketed in America and, like any other successful marketing program, consumers respond. Therefore, when the subject of health system reform comes up, proponents of reform are told about Americans' strong appetite for health care; that Americans would not put up with this or that. We hear that, however, from the sellers of health care, not consumers.

Another red herring often heard is that any effort to get tough on the cost side of the equation would cause a rationing of health services in America. First, we should never fear rationing excess; instead we should seek to eliminate it. Second, we should not entertain such arguments until the medical experts who are regularly reporting on the high volume of unnecessary and ineffective medical care rendered in this country report that this problem has disappeared. In short, the rationing scare-tactic employed by some in the medical community, insofar as it is intended to relate to necessary health services, or that it is an inescapable result of any tough cost management effort, is not supportable.

Evidence of delays in providing certain elective services in Canada, for example, are often cited by some. First, Canada is in its thirtieth year of hospital controls and its twentieth year of physician controls and has relied almost exclusively on resource constraint to accomplish its cost objectives. Accordingly, it is not surprising that there exists today a certain tightness in parts of their system. More fundamentally, however, and notwithstanding the exceptionally high approval rating Canadian citizens give their health plan, it appears that if Canada were to employ some of the managed care techniques in use in America, they would generate additional savings which could be used to add resources to their supply side and yet operate their system at a lower overall cost than they do today. You need appropriate controls on both the supply and the delivery side.

Given the above scenario, the health insurance industry in America has a major challenge. Today we suffer from an excessive dose of administrative costs which are a byproduct of our fragmented, uncoordinated health system. This administrative cost burden has not produced the savings which one would otherwise expect from a pluralistic, competitive system. We submit insurance companies will only have a role in the future if they bring value added to the transaction. Packaging efficient networks of doctors and hospitals, coming to agreement with them regarding practice standards, and selling such a package to employers can be quite consistent with a national strategy of enhancing the quality and

reducing the cost of health care in America. Serving as a risk pooler and money conduit may not be, unless they are the most efficient in filling that need.

In conclusion, the process of accomplishing health system reform will be very tough. But, it will be tougher if we delay. While we can appreciate how this process of reforming a broken system must take seriously the concerns of hospitals, physicians and insurance companies, the overriding need of American citizens and American business to have an affordable and cost-competitive health system demands that we not overconcern ourselves with having to build on a shaky foundation. Any final legislation resulting from the Pepper Commission recommendations or from other options under review which presumes a continued role by business in financing health care must consider how that role will affect the cost of production in America and the resulting impact on international competitiveness.

As a nation, we must focus on the causes of the health cost problem, not its symptoms, in framing solutions. There are many system reform proposals currently being debated by interested parties around the country. Chrysler intends to continue to work closely with Uwe Reinhardt and the many others who share our goal: a more equitable and rationally priced U.S. health system. We also intend to continue improving the efficiency of our health benefit program and, in general, increasing overall productivity.

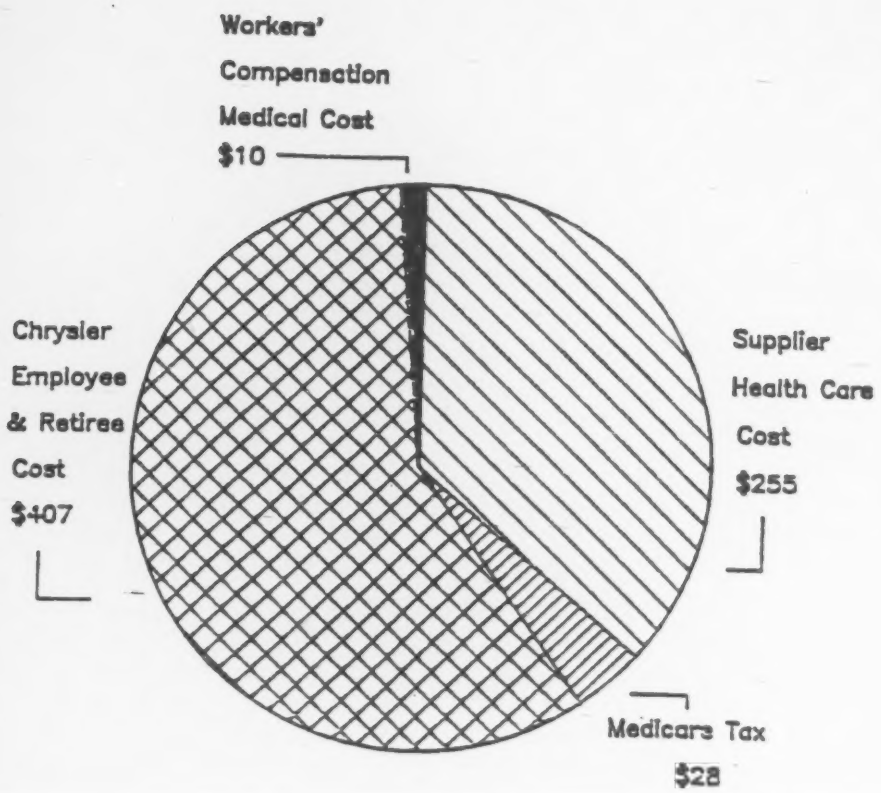
When all is said and done, however, it must be recognized that, irrespective of the harmful impact health costs have on U.S. business, it is the American citizen who ultimately pays the price of our health care system. Citizens pay in the form of higher doctor bills, heftier insurance premiums and increased taxes. An employer's ability to increase wages, even in a unionized business, is influenced. Prices of goods and services are also affected. Citizens also are victims of a deteriorating national infrastructure, an inferior education system, and many other indicators of a government strapped for funds, in part because of our nation's high health costs. Worst of all, citizens are at risk of paying the supreme price of losing a job, because their employer's business failed due in whole or in part to the unconscionably high cost of health care in America or because their employer automated or outsourced their job in hopes of reducing labor costs.

A business can do that; it can reduce health costs by reducing the number of employees, in short by reducing the number of patients. A nation should not have to do the same thing. It should not have to export citizens to reduce health costs. Nations do, however, export jobs and that is what is going on in America today and what will continue to occur until we decide to take the bold steps necessary to make our nation's health system cost competitive.

Exhibit 1

CHRYSLER HEALTH CARE COST PER VEHICLE

1988 – U. S.

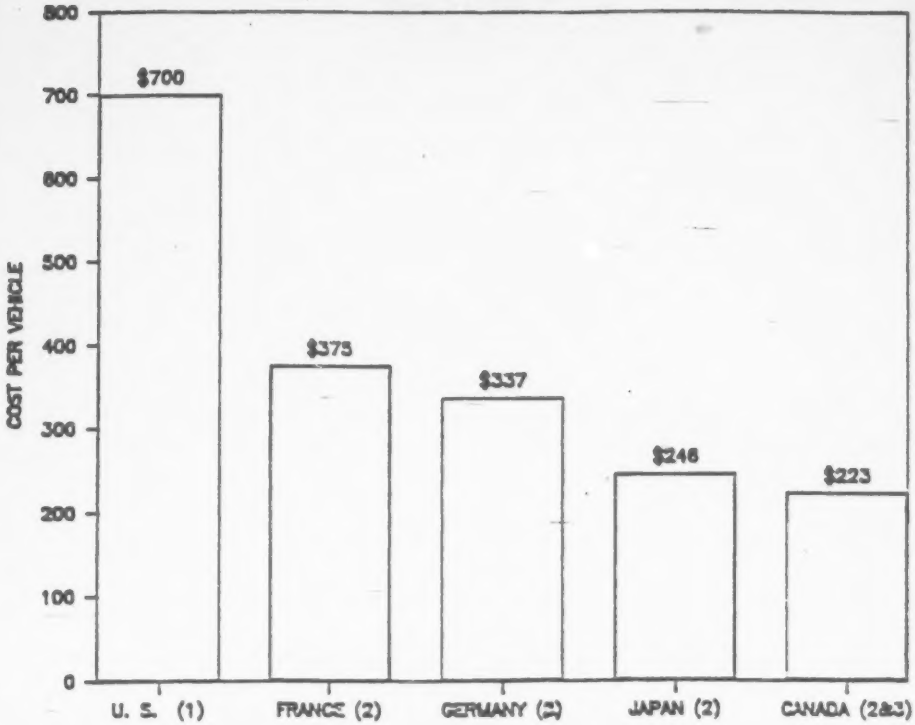

Workers' Compensation Medical Cost $10
Chrysler Employee & Retiree Cost $407
Supplier Health Care Cost $255
Medicare Tax $28

TOTAL: $700

Exhibit 2

HEALTH CARE COSTS PER VEHICLE

-1988-



(1) Includes employee and retiree premiums, Medicare payroll taxes, Workers' Compensation Medical costs and imputed supplier health care costs.
(2) Includes payroll taxes and imputed supplier health care costs.
(3) Excludes general tax payments

Representative HAMILTON. Thank you, Mr. Maher.
Mr. O'Neill, please proceed.

STATEMENT OF PAUL H. O'NEILL, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, ALCOA

Mr. O'NEILL. Thank you, Mr. Chairman.

Rather than summarize my prepared statement, which is a short one and, I hope, readable, I would like to offer a few comments beyond the prepared statement.

First, I would like to say that I feel a certain degree of resentment in Professor Reinhardt attributing to me points of view which I do not hold and using, apparently, a convenient academic, simplified assumption that all business people are the same. I don't mind being attacked, but I would like to be attacked for what I believe, not for what is ascribed to me.

In addition, I would like to make a distinction as between myself and my friend from the Chrysler Corp. I am not here representing ALCOA. I work for ALCOA, but I am representing what I think about these important issues.

I think, as I say at the end of my prepared statement, that there is a very, very important social policy issue underneath the questions that we are here to discuss today. That social policy issue is one we have dodged and ducked and done our best to keep off the public table. And that is: Does it mean anything at all for a person to be an American when it comes to health and medical care?

I think the accumulation of programs and tax incentives and direct delivery care is a dodge of the most fundamental issue. I am quite concerned that unless we stop and give some life to the notion of creating an agreement as to what it is that it means to be an American, that we are simply going to keep going down the path we have now been on for some time toward effectively a Federal system of health and medical care, which I expect will lead us to control prices and wages in a very direct way, to the detriment of quality and innovativeness in our health and medical care system.

I am not one who believes that we should so readily accept the notion that we have fallen into—and I think it is represented by Mr. Maher's testimony—that somehow American businesses have a special capability in the purchase of health and medical care.

I think my own firm is quite good at making alloys for aircraft parts and for making aluminum beverage cans I hope you all use every day. But I don't know why everybody thinks we have some special angle on the ability to intervene in what is perhaps the most personal of all purchase decisions; namely, the consumption of health and medical care.

It seems to me quite apparent that it isn't true, and it's also quite apparent that the Federal Government and the State governments and the local governments have also found that it is not so easy to intervene in that most personal of human decisions. I am not willing to accept the notion that somehow we can control health care costs because of the so-called purchasing power capability of big firms.

The people who make alloys are not people who are good at deciding whether or not someone needs an appendectomy tomorrow morning. And while there is some merit to the notion that we may be able to use our purchasing power vis-a-vis the insurance companies, I would say to you the value of that purchasing power is with regard to their administrative costs because, in effect, although they are moving beyond it now, they are really a collector of bills and a payer of bills. They also are not capable of directly intervening in the purchase and consumption decision of an individual provider of health and medical care.

I am concerned that we are moving down the track without examining the fundamental assumption that we have long made about the role of business in this area. It strikes me that I don't have a program for my people for automobiles or food or some other things that are less personal consumption decisions, but here I am in the middle of health and medical care.

It seems to me also worth stating—because I think Professor Reinhardt is right on one point—health care costs—that our accounting system distinguishes separately—are indeed a part of total compensation. And so I do not, in a narrow sense, see health care costs as a pressing reason for loss of competitiveness in a microeconomic way.

Let me finish by saying I think we would be well served if we would adopt Professor Reinhardt's notion that it is all compensation and eliminate the tax avoidance that our current tax system provides to individuals for health insurance costs that are bought on their behalf, as a beginning step in moving back toward a system that recognizes the importance of the individual helping to make a decision about how much of their total compensation goes for health and medical care.

Thank you.

[The prepared statement of Mr. O'Neill follows:]

PREPARED STATEMENT OF PAUL H. O'NEILL

Mr. Chairman and Members of the Committee,

I appreciate having the opportunity to testify on the subject of health care costs and the implications for the competitiveness of U.S firms.

The unrelenting escalation in health care costs and the relative decline in the world competitive position of some U.S. industries are both critical issues for our society. These two issues are related to each other but not in a simple way.

The productivity of resources in our health care sector is important because the sector comprises a significant part of our economy. In a world where competition is getting stronger every day the total productivity of our resources must equal or exceed that of other nations if we want to maintain or improve our standard of living. To the extent that the health care sector is a drag on productivity it is a drag on the living standard of our society.

There is no doubt that there has been a significant shift in the composition of our economy over the last thirty years. The share of our economy devoted to the health care sector has doubled, from six percent of our gross national product to

twelve percent of our gross national product. These facts are easy to observe. It is not so easy to determine the impact of this shift on the productivity of our total resources. Circumstantial facts, however make it clear we, as a nation, are spending substantially more on health care per capita than other nations while our indicators of health status are worse than those of other nations.

In a theoretical economic sense, one might very well say, so what? The essence of our economy is to allow people to spend their money in any legal way they wish. From the point of view of an individual firm, we don't wring our hands if our employees decide to spend a disproportionate part of their income on clothes, or automobiles or housing. Why should we care if they decide to spend a larger share on health care? I don't think individual firms would care if it was not for the fact that they have gotten caught up between employees and health care providers as a consequence of the inducement in our tax system for employees to prefer protection against health care costs (health insurance) over cash income.

It is not difficult to understand this preference at a time when health care costs are and have been rising at twice the rate of general inflation in the economy and the tax code allows individuals to exclude from taxable income the value of employer-provided health insurance.

As health care costs have escalated, the response of individual firms has been predictable. They have attacked this element of cost as they would any other. From the point of view of individual firms, I think it can be demonstrated that this attack has been somewhat successful in reducing the rate of increase of health care costs. But it is a major mistake to think that business payers of health insurance premiums are the answer to our society's problem with health care cost control.

With the advent of the dominance of third party payment systems, we have crippled the ability of the price system to ration health care and so we are reduced to trying to do the job administratively. I wonder, does anyone know of an example of a price control system that has worked over any extended period of time? I don't.

None of this is to argue against the desirability of pooling pre-payments for health care in order to moderate for the individual the episodic nature of the need for medical attention. Nor would I argue that it doesn't make sense to use a payroll deduction system to collect the money for health insurance payments for the employed. Doing so is analogous to the administrative collection job that firms do for the I.R.S. in collecting withholding taxes. But also please note, businesses do not assume the responsibility for keeping an individual's tax low simply because they perform a collection service for the individual and the government.

We are far beyond this now, to the point that the public dialogue begins with the implicit assumption that firms have a major role to play in health care cost containment, and that if any change in direction is made, it will be to mandate universal health insurance coverage through employers. It would not be surprising to see that step taken; in fact, there seems to be a growing sentiment to skip over that step and jump to national health insurance. I wonder, does anyone think national health insurance will reduce medical care cost escalation? Of course, the answer to this questions is, health insurance coverage is about equity, not about cost control. Unfortunately, the cost problem will not go away and as a consequence we are sliding down the slope into a nationally administered wage and price control system for our medical care sector. As we add more pressure to the

system in pursuit of universal "equity," costs will escalate at an increasing rate and the Federal Government will have to reluctantly move beyond the current facade of setting prices for "procedures" to setting compensation levels for health care sector employees in order to control national spending for health care.

It seems obvious to me that this is where we are headed. We have been slipping and sliding down this slope for the last twenty-five years and we may be beyond the point of having a choice. At the end of this slope is a system that looks like the British system. (In time, the Canadian system will "mature" into a British system.) Less innovative than the best of our current system, less brilliant at the leading edge of research and the development of new technology. Less attractive to young people for careers. Broader access. Controlled by the Federal Government.

And if we do get to the end of this slope, the real problem that we have studiously kept out of the public dialogue will be waiting for us. Namely, in the absence of a price system, how does the society decide how much it is willing to spend to enhance or save or prolong a life. As much as we may want to turn away from it, this is the real issue. It is such a difficult issue that it is certainly more comfortable (and entertaining) to talk about the impact of health care costs on the competitiveness of U.S: firms.

If my assessment is correct, we could do our society and future generations a great favor by concentrating now on this central issue.

Representative HAMILTON. Thank you very much, gentlemen.

Your prepared statements, of course, will be entered into the record in full.

Let's begin with exploring a little further this relationship between health care cost and competitiveness. If you just look at the overall system of health care in this country and compare it with our industrial competitors, I think it's accurate to say that in our country most workers have private insurance through their employer and that that costs money, whereas industries in other countries operate under a system where you have a national health insurance system of some kind.

Does that fact in and of itself put the American business enterprise at a disadvantage, and how much of a disadvantage is it to you in a competitive world?

Mr. MAHER. Maybe I will start, Mr. Chairman.

If the question implies do we need a single source of revenue, it's not a model of a Government program as the be-all and end-all answer. I don't think that is necessary at all. I believe the inherent difference between the system in the United States and those abroad is the divide-and-conquer point that Professor Reinhardt makes in his prepared statement, that we have buyers each trying to outdo the other. We have a massive presence by the public sector. Forty cents out of every health dollar is paid by some public sector program: Medicare, Medicaid, and public health programs. And they have the ability to do their own thing.

The private sector is going out and buying health care in that same market, the same market that is impacted by the public program, the way they pay, they use controls they put into place or fail to put into place, the supply-side expansion that is made possible by reimbursement for capital expenditures and medical education without any regard for whether we need the additional supply or whether we are educating more dermatologists than primary-care physicians. The dollars going to support medical education are just a piece of hospital reimbursement, which, frankly, if you are doing it without regard to need, that lack of coordination is what really separates us, I think, from the rest of the world.

Representative HAMILTON. I am not exploring with you at the moment what kinds of solutions we ought to have. I don't mean by my question to tilt toward any particular solution. What I am trying to drive at is, as an executive of Chrysler or ALCOA or whatever, do you consider the fact that you have to provide health insurance, in the employment setting, a competitive disadvantage relative to your competitors overseas who have a health insurance system that is financed largely by general tax revenues?

Mr. MAHER. There is one other vital difference: In other words, businesses around the world, Mr. Chairman, help finance the system. The German companies do it; they just do it on a payroll tax basis. The same in Japan.

One big difference is the health cost of that business is not tied to the demographics of your work force. In America, the health costs of a business, if you happen to employ a work force of average age 50, your health costs are going to depend on the demographics and the luck of the draw of your employment pool. Those costs, particularly relative to the aged, are spread much more consider-

ably over the economies in other countries. Therefore, I think that tying health care to employment from that point of view creates a meaningful difference.

Mr. REINHARDT. I also would alert you to the fact that, for example, in West Germany, the bulk of health care is financed through the payroll tax, which is on average about 12 percent of total gross compensation. And here, on average it is only 8 percent. So that can't be the problem.

The real problem is that all of these countries have one-payer systems. Basically in Germany you have a thousand different sickness funds; they join together at the regional level in an association that negotiates doctors' binding fees, hospital rates, jointly with associations of hospitals and doctors. Therein lies a better social contract, I think.

And Mr. Maher is quite right, it is the multitype, divide-and-rule system that has driven the cost of health care in America to a level—and you quoted me quite correctly—that has maximized the slice of the GNP that is paid for health care. It is endemic in that system.

Now, this is what puzzles me. I was commissioner on the National Health Leadership Commission, and we had proposed, Mr. Stewart Altman and I at the time had proposed, an all-payer system to get rid of the cost shifting business deplores so much.

And I do apologize to Mr. O'Neill if I attributed to him remarks or thoughts that he doesn't hold. But his representative on that commission certainly suggested that he was not in favor of an all-payer system and that ALCOA was perfectly capable of taking care of itself in the health-care market, using its own market muscle, that is, shifting costs further down the pike to less powerful small business firms.

If that doesn't reflect Mr. O'Neill's view, I am delighted to hear it, and I apologize for the attribution.

I believe ultimately, after much agony, this country will slide toward an all-payer system on the West German model—not the Canadian model but the West German model—because ultimately that will be the only way to stop these pretty unseemly economics of the hot potato where big payers—Government being the biggest—shift unrecovered overhead of the health system to big business, then big business turns around and shifts it to small business, thereby strangling the entrepreneurial edge of America.

Ultimately, we will discover what these other nations long ago discovered: that in health care, the free market doesn't work, that you must somehow have a social contract under which all payers pay the same provider the same fee for the same service.

Mr. O'NEILL. Mr. Chairman, to come back to your question about the degree to which health care cost creates a competitive disadvantage, as I said earlier, I agree with Professor Reinhardt's formulation. I think over a reasonable period of time, health care is a part of total compensation, and at the end of the day companies' revenues have to exceed their costs, or they are going out of business.

When I think about my total cost position, I don't particularly single out health and medical care. To the degree that we have been successful in reducing our health and medical care costs as

compared to the general rate, I think it is true that that money has been given back, in effect, in cash income.

But there is an important shift taking place because of our total compensation levels, which do include health and medical care costs. I have seen it in my own business, and I am sure from your individual districts you see it as well. It is no secret that more businesses are moving to lower compensation countries when labor is an important ingredient in the value-added process.

You only need to go across the border into Mexico to see the economic activity that is taking place there. And if you want to go a little bit farther away, you can go to Korea or you can go to Taiwan.

And you can see, I think, in the last 30 or 40 years that we have proven without any doubt at all that there are no longer any barriers to the transfer of capital and technological ideas and to the ability to quickly educate people into how to do very complicated tasks.

As a consequence of that, I think beyond a shadow of a doubt, we are shifting industrial activity—and not just industrial activity but other kinds of intellectual activity—to lower cost labor markets which includes the health and medical care component.

I will give you an example in the intellectual area. The chairman of a large international construction company was telling me that, with the advent of computers, he is now getting a lot of his design work done in Taiwan because it's very simple to send the electronic signals to Taiwan and an engineer in Taiwan will do the work for $8 an hour.

That is not to suggest that we move ourselves down to their standard of living. But I think there is no doubt that our compensation levels and in fact our standard of living are under attack.

To come back to my main premise, I think it is imperative that we push ourselves to be competitive in all that we do in our society—whether or not it shows up in the accounting books of my company—because it's important for the living standard of our next generation.

Mr. MAHER. Mr. Chairman, if I might, while I disagree with the very start of what Mr. O'Neill said but I think he made my point in the balance of his statement, business is doing exactly what he said. They are not lowering the standard of living of a worker by shifting health costs; they are destroying it. They are laying the person off and shipping the work offshore, chasing low labor rates. Or they are buying a robot; robots don't get issued Blue Cross cards.

That is what is going on, and that is not an appropriate policy for this Nation, although it is something that an individual business can do because their labor costs, impacted, in part, by health care—health care is not the only element of labor costs which are driving business to do exactly what Mr. O'Neill said.

Representative HAMILTON. Before turning to Congresswoman Snowe, let me just ask you as executive officers of major American corporations, do you spend a lot of time on health care? Has that become a major focus for you and your top executives?

Mr. O'NEILL. I spend a fair amount of time on it, but not in the context of my individual company. As you know, I am a member of

the Quadrennial Review Commission on Social Security, and its major focus in this quadrennial cycle is on health and medical care. And yes, indeed, I spend a lot of time working in that context.

Do I spend a lot of time directly on the subject of health and medical care in my company? I would say not a lot. But our organization, like the Chrysler organization, has done all of those leading-edge things that big companies have been doing in terms of urging the utilization of health maintenance organizations and working toward preferred providers. The fact that we are doing it shouldn't suggest that it is a solution to the problem. I think it is no solution at all.

But so long as we are confronted with the system we have now, we will do our best in shifting everything we can away from us because it's the only thing we can do.

Representative HAMILTON. Congresswoman Snowe.

Representative SNOWE. Thank you, Mr. Chairman.

Obviously, you all represent an interesting point of view on this issue, and it's an issue that is of increasing concern to the American people. I know that, going around my district, people tell you this has become one of the major issues and will continue to be.

As we see the demographics in this country, our problems are going to get worse. Our health care costs are going to increase over time because we represent an aging population.

Starting with you, Mr. Reinhardt, you mention an all-payer system. How then do we get at attacking the fundamental problems of our health care system and reducing costs that don't necessarily reduce the cost of our overall health care system? In fact, this could represent an increased cost to individuals.

Mr. REINHARDT. When we talk about health care costs, there are really two types of costs. One is the real resources we divert away from other potential uses toward the health sector. For example, the person who becomes a nurse rather than a teacher; a physician rather than a physicist. That's one cost—the so-called real resource cost of health care.

The other one is that I would call the transfer cost. That is the vouchers, dollar bills per unit of real resource we have to transfer to doctors and hospitals for, for example, a coronary bypass: Do I transfer $3,000—as we do in Atlanta—or $8,000—as we do in New York City?

So when we talk about an all-payer system, the idea there is, in the first instance, that we would transfer fewer vouchers to providers, but in fact you will get the same health care more cheaply in terms of money.

For example, in Canada, a surgeon is paid $1,200 for a coronary bypass. That's what the surgeon gets paid. In Philadelphia, it's anywhere from $3,000 to $8,000, depending on what the surgeon charges, and what business is willing to pay.

So that is one thing. An all-payer system per se will not reduce the real resource cost; that is, the excess hospital beds, the unnecessary surgery that is apparently performed. For that, we need different mechanisms. But this Congress has moved in the direction of addressing that problem. The Department of Health and Human Services has been quite visionary in the 1970's in funding research that would point out this waste. And Congress has recently legislat-

ed the establishment of an agency, and the funding for it, that would go after the research on outcomes and appropriateness, where we hope that once we have this knowledge we can eliminate such waste as there is.

But those are different policy strategies. The all-payer system addesses mainly the money transfer per unit of real health care resource. And there we could do a bit better than we now do.

Representative SNOWE. Where does mandated health benefits come into an all-payer system?

Mr. REINHARDT. First of all, I will predict that we will have a mandated health care system, although we will probably call it the "All-American Private-Public Judeo-Christian Health Care Partnership Act." [Laughter.] As such, President Bush might sign it.

But small business, and rightly so, will accept that kind of legislation only on two conditions: First, that the underwriting standards of the insurance industry be tightly regulated. In plain English, small business will ask for community rating. A small business doesn't want to pay a higher premium than a nearby competitor just because one worker is a diabetic.

Second, small business will say, "I want health care on the same terms Chrysler and ALCOA get it. I don't want to pay more for an appendectomy than Chrysler does." That, of course, is a request for an all-payer system.

And it is basically that scenario I have in mind: Mandated benefits, regulated insurance industry, all-payer system—bingo, the West German type system that I believe, by the year 2000, will be in place in the United States as well.

Representative SNOWE. Mr. O'Neill, how do you feel about mandated health benefits?

Mr. O'NEILL. I am for mandates, but I am not for mandates on business. I think it's time that we asked ourselves the question: "What do we as a society believe is the minimum level of access that should be provided to every American?"

If we were to ask ourselves this question, we would do something very different than your question implies, mandating on business. Again, let me say I agree with Professor Reinhardt's formulation that health care is part of compensation. Therefore, when people talk about putting a mandate on business, it's wrong headed. It's worse than wrong headed, it's stupid.

I think we would be well served if we would say to ourselves, for every person in this society—you will be entitled to 3,000 or 4,000 dollars' worth of medical care if you have zero income. If you have enough income—above some cutoff level—we will require you to have insurance coverage so you don't become a ward of the State at your own election because you decided to buy a new car instead of having appropriate health care coverage for you and your family.

I am for that kind of a mandate because it forces us as a society to deal forthrightly with an issue that we have been unwilling to face. It is a disgrace what we have in Medicaid because what we have now is a system that says how much we care, depends on where you were born or where you live. We are using the tax money collected from the entire population to discriminate against individual Americans with regard to what kind of coverage they have for health and medical care.

So I am for getting away from the subterfuge of mandates on business and distinctions between public and private. We ought to deal with this as a human issue. It would solve an awful lot of problems.

Representative SNOWE. Mr. Maher.

Mr. MAHER. Relative to the issue of a mandate, we believe that we ought to have a system in this country where everyone has access to some affordable health care system. There ought to be a niche for everyone. And that in terms of providing the financial resources for that system, that you can't carve out some segment of the economy and say you don't have to participate in the financing of this.

Does that mean that the thousands of small business people who don't offer insurance—and it's an astounding number; they employ under 15 percent of the population, but they represent 75 percent of the employers. To the extent they can't afford to see their friendly insurance agent to buy a product, that doesn't necessarily mean that they shouldn't in some way finance the system, whether that's through the tax system or otherwise.

But I don't see how you carve a portion of the economy out and say you are immune from, in some way, contributing to the support of the system.

The problem of small business becomes even worse if in the health system reform debate we decide, all right, we're going to pay out of the public sector, take care of the poor and the elderly, and employers take care of the working population. That is a public policy decision. Congress has to come to grips with what do you do with the small employers unless we have some other means that we use for them.

What I am concerned about is that these legitimate concerns of the small business community who, frankly, a lot of the proprietors don't even have insurance, and they don't perceive this as like an increment to the minimum wage and that they can therefore price for it because their competitors would be similarly impacted. But it does represent a substantial increment to them.

If this can't get resolved and as a result it stalemates the whole reform process that all businesses certainly ALCOA's and Chrysler's really need, I think we have to really then take another look at the employee benefit system and question whether we have to in some way perpetuate it—as Professor Reinhardt indicated, this is almost an accident of World War II—and then perpetuated it through the tax policy of this Nation.

Or should we not then look at some other system of financing health care, realizing that the business community that is now pouring in about $140 billion a year is going to have to probably contribute a like amount regardless of what system in terms of financing, because it takes a lot of money to run a health system?

Representative SNOWE. Mr. Reinhardt.

Mr. REINHARDT. I do want to say that I view mandating employers to provide health solution as the second-best solution. The first-best solution is the one Mr. O'Neill mentioned, and it is to mandate the individual. You can make a good ethical case for that. Because we feel obliged to help an injured motorcycle rider, we are entitled to mandate that he or she wear a safety helmet and carry

adequate health insurance. Then, having mandated that upon the individual, however, it is the obligation of Government to make sure that an individual family can actually get health insurance at an affordable price. The Government must offer the people a fail-safe health insurance policy.

Because I am always peddling ideas, I took the cheek of adding to my prepared statement a piece I had in the Wall Street Journal proposing just such a system. It is called a fail-safe system, where health insurance would remain a voluntary part of the labor-management contract but there would be a federally financed State-administered fail-safe system that would catch anyone who isn't privately insured. And the premium the individual would pay for that policy would depend strictly on the income of that individual.

That is to say, for poor people the policy would be free, and then as one's income rises, one would pay a progressive income-tax premium. Government could use that tax premium to drive people either into the private or public system, depending on prevailing ideology. That, in a way, is a more elegant or more complex statement of the Medicaid buy-in. I would abolish Medicaid totally. It would become part of the fail-safe system. Ideally, one would want to fold Medicare into it as well, although I am too cowardly to explore that issue here.

At some point, however, this nation may have to discuss whether it was wise or moral to give free cataracts to retired millionaries and to kick working women with children off Medicaid. I have a view of this. But maybe airing that view would lead us too far astry this morning. [Laughter.]

Representative SNOWE. Thank you.

Representative HAMILTON. Congressman Obey.

Representative OBEY. Mr. Chairman, I am frankly not quite sure what to ask, because I have been in this puzzle factory 21 years and I see more dissembling now than I saw when I came, on the part of everybody in society on this issue.

Before I ask the main question I want to ask, though, and I apologize for not getting here on time, I missed your statement, Mr. Reinhardt, but I want to ask again the same question or roughly the same question the chairman did because the hearing is focused on the question of competitiveness.

And I guess what I want to ask is: Are each of you saying that the existing system really puts American business at a disadvantage competitively? Very briefly.

Mr. MAHER. I might as well start because I think I am the one that most clearly agrees with an affirmative answer to that statement. And my point is that I don't think any of us disagrees at this table that the health costs in this country, the system is infinitely more expensive than anywhere else. We are 40 percent more costly per capita than anywhere else.

Representative OBEY. Putting that aside for the moment, I don't want to get into questions of cost control, because that's a different question. My question is a very simple one and can be responded to, I think, with a very short answer. Are you saying that the existing system, primarily the way in which it is financed, creates a competitive disadvantage for American business?

Mr. MAHER. Yes. American business must compete for labor domestically, we must compete for price on a worldwide basis.

Representative OBEY. What would the response of the other two panelists be?

Mr. O'NEILL. Congressman Obey, as I said in my testimony, I don't think the answer is simple. I do think that we have ended the era when our society could blatantly waste resources and expect to maintain our standard of living. My interest in this issue is more in the question of how we can get greater efficiency in the use of our resources.

But from an individual company point of view, just as Professor Reinhardt has said, there is an upper limit on what I can pay for compensation and everything else that goes into my cost function and still compete in the world. And to the degree compensation includes health care costs, which it does, it is an important element. But does it make me noncompetitive in the world?

Representative OBEY. I didn't say does it make you noncompetitive. Does it put you at a disadvantage?

Mr. O'NEILL. In a direct sense, I don't think so.

Representative OBEY. Mr. Reinhardt, you don't think it does?

Mr. REINHARDT. I don't think it does, and I have laid out the reasoning in my statement.

Representative OBEY. I guess my question would simply be this of the business community, if it has your view: I have introduced legislation which you would describe as being stupid. I think Mr. Reinhardt would describe it as being the second-best solution because it involves mandates. It sure as hell isn't my first preference. But I will tell you my frustration.

When I came here in 1969, I remember sitting in the Longworth Building barbershop getting a haircut, and Ed Beamon, a lobbyist for the AFL–CIO, was sitting in the chair next to me getting a haircut. He said, "Dave, I see you're not on the Kennedy national health insurance bill." I said, "That's right. I'm not." He said, "Well, your workers are going to be very upset about that."

I said, "No, they're not. I just finished polling my district. The No. 1 group in my district most opposed to national health insurance is labor union families, because they have theirs. So they're not much worrying about some poor devil who doesn't."

At that time, when I asked the question in my district, "Do you believe that the Government has a major responsibility for providing health care to the uncovered in this country, or do you think it is primarily an individual responsibility," I got about 60 percent saying it was primarily an individual responsibility.

Today, if I asked precisely that same question, I would get a 70 percent response the other way. And therein lies the dilemma, because the public wants coverage but they don't want to pay for it through taxes.

I have heard a lot of businesses tell me that they are upset because they do think that insurance is making them noncompetitive. But when I ask them what do you want to do about it, the answer is generally nothing. The answer is generally that they want us to let some poor bastard pay for it—pardon my French.

But they don't want to have to deal with it. They don't want to be part of any coalition which insists that the Federal Government

establish some kind of rational system under which there is a shared responsibility by the recipient of the service and society, to make certain that the burden is shared in a roughly decent way.

So I think we arrive at the issue of mandates because, in plain English, the business community does not have the willingness to insist that we go further. And I don't know how to overcome that.

If I were a businessman, I wouldn't want to have mandates thrust upon me. But I would hope I would be realistic enough to suggest an alternative solution. And that is what I don't see.

I guess what I would ask each of you is this: Assuming that not much happens to our health care system for the next 5 years, what do you think you will see the Chamber of Commerce, the NFIB, the National Association of Manufacturers, and the other business groups in society, what do you think you will see them lobbying for as a solution to this problem 5, 7 years from now, if they don't want to be stuck with a mandate? And in my view, they are going to get stuck with that mandate lock, stock, and barrel unless they come up with some other approach.

Mr. MAHER. Let me start. If I were going to take Mr. O'Neill's position, I guess my answer would be: Nothing, because this is irrelevant, it's just part of total compensation and they're going to be adjusting wages, and the Chamber will be worrying about something else.

I obviously don't by this total compensation theory, because you just cannot keep squeezeing and eventually arrive at a system where workers are getting paid solely by their Blue Cross premium. I think what you are starting to see there is one issue that the business community has really come to grips on, and that is the Government has to stop cost shifting. Public programs have to be efficient.

My belief is that once that happens, so much in the public-private sector will flow from that because people who start off by saying, "Rate regulation is bad. We oppose all-payer systems," if they buy on to the fact that Government can't cost shift, I say, well, all right, what about you, Mr. Chrysler in Detroit, should you be able to cost shift to Joe's Tool & Die? I don't think so. Where does that drive you? I think it drives you, properly so, to a coordinated payment process system where we don't have $8,000 versus $3,000 and, hopefully, arrived at through some process other than take it or leave it.

But the Government is frankly not going to have a gun held to its head by ophthalmologists on the price of cataract surgery. If Government has to pay their own way on the supply side and medical education, as they should, query should the taxpayer just open their pocket and say, all right, you got 40 percent, just send me 40 percent of whatever the hospital construction bill has to be that year? Not at all. There would be, hopefully, a well-regulated process in terms of how much public money is going to go into hospital and medical education as opposed to the type of health planning we had in the 1970's.

Now you have to do this on some sort of budgeted basis because while the Government has to pay their fair share, they can't break the bank. Does that lead you into more regulation such as we see in Germany and Japan, where there is some very major central

control over the supply side? Yes. Is that bad? I don't think so. And that process will start to be absorbed by the business community and we will start to see a lot less adverse reaction to what may appear to be "regulation" because you can have that and also have a market in the delivery of health services that hopes to have the rewards go to the best-quality providers.

I think you can have that coexisting with the system where you have more regulation, so to speak, on unit price on the supply side, medical education, et cetera.

Representative OBEY. I know you think you can have that, but do you think that is what the business community will be lobbying for in 5 years?

Mr. MAHER. I am an optimist. I hope this problem is resolved before 5 years.

Mr. O'NEILL. I think the track that the business community and generally the society is on is moving very much downhill toward a federalized system. As I said in my prepared statement, with the need to control costs, we are headed toward the control of total compensation for providers—a full-fledged Nixon 1971 wage-and-price control system for health and medical care, which I frankly think is a disastrous answer.

I do think there is a better answer, but it's not called national health insurance. It's back to what Professor Reinhardt and I were saying before. It is to say it would be great if Representatives and Senators could say to people, "The Government doesn't have any money—it doesn't first take away from you. But we as a society don't want to be faced with the dilemma of someone showing up on the stairs of a hospital and being turned away and dying because it affronts our view of what it should mean to be an American citizen.

"Therefore, individuals are required to have a certain amount of coverage so we don't have to face the moral dilemma of your showing up and dying on the steps of a hospital. And for low-income people, we need to say, it is the obligation of the society to provide them with access to medical care and we are going to take the necessary money away from people in society in general in some sort of proportional or progressive way and we're going to give it to the low income people."

It is awful, and not only in this health and medical care area, that the dialogue is not an honest dialogue about the fundamental issues that confront our society. I don't think we're living in the kind of preeminent, economically advanced society as compared to others that we did 30 or 40 years ago, and I don't think we can get away with the subterfuge and the deceit and the dissembling that you mentioned.

If you look in the morning newspaper and see where we are headed as a society, we are headed down the road of businesses joining others in pushing for national health insurance. The reason they do is because the average cost of a federally run national health insurance system will be lower than the obligations they face if they stay on their current track—not because it's good for society but because it's in the interest of their current position which they have gotten themselves into.

Mr. REINHARDT. You asked, Congressman Obey, about the business community. That is an interesting question. What will it call for 5 years from now? As I mentioned in my statement, getting, say, the Business Roundtable to evolve a statement on health policy now would be more difficult than making eagles fly in formation, or cats walk in step.

When it comes to health care they suffer a total intellectual disarray around that Business Roundtable. In fact, I would love to have the privilege to make a very blunt presentation to that Roundtable just to tell them how bad their intellectual problems really are.

I think Mr. Maher is one of the few American business executives, and possibly the only one I know, who has taken the trouble to think through this entire issue, and to put it to paper in a 10-page-or-so statement that one can even react to.

One doesn't have to agree with everything in Mr. Maher's statement to congratulate him for it. I think it's a good start that at least one American business executive took the trouble to write down his thoughts. Maybe Mr. Maher would like to share what he wrote, with this committee. It is a statement other than the one he submitted for this hearing.

My own sense is that probably there will be a split in the business community. Some of the bigger firms may be able to take care of their own health-care costs a little better by shifting costs to small business. The data show that this is possible—see the National Association of Manufacturers' data. But small business and the Chamber of Commerce, who represents them, will find their premiums go up 20 to 30 percent, quite capriciously, and they may be asking for regulation of underwriting standards in all-payer systems even before a mandated benefit would come down the pike.

As to the mandated benefit, it is in fact the case that Germany, Japan, France, all these countries, mandate health insurance upon their employees. Countries that do not do that are very few and far between. Canada doesn't, because the Government finances it with taxes. And that is why I want to reiterate, I do believe there is a superior alternative but it requires income taxes, which Americans don't like. Mandated benefits is a hidden tax which Americans are more ready to pay. If that is the only game in town, then I am 100 percent for it. So I would certainly not label your proposal with a negative adjective. I believe that is indeed the way we will go in these United States.

Representative HAMILTON. Senator Bryan.

Senator BRYAN. Thank you very much, Mr. Chairman.

I would like to ask unanimous consent to include my written opening statement as part of the record, if I may.

Representative HAMILTON. Without objection, it is so ordered.

[The written opening statement of Senator Bryan follows:]

WRITTEN OPENING STATEMENT OF SENATOR BRYAN

MR. CHAIRMAN: I WOULD LIKE TO COMMEND YOU FOR HOLDING THIS HEARING ON A VERY TIMELY AND VERY TROUBLESOME NATIONAL CONCERN. FEW ISSUES OF PUBLIC POLICY RAISE MORE COMPLICATED SOCIAL AND ECONOMIC IMPLICATIONS THAN THE COST AND AVAILABILITY OF HEALTH CARE IN THE UNITED STATES.

DURING THE 1980'S, THE COST OF HEALTH CARE IN THE UNITED STATES HAS EXPLODED. AS A NATION, I BELIEVE MOST WOULD AGREE, WE SPEND MORE OF OUR GROSS NATIONAL PRODUCT ON HEALTH CARE SERVICES THAN THE OTHER INDUSTRIALIZED COUNTRIES WE MEET IN THE INTERNATIONAL MARKETPLACE. DESPITE SPENDING LESS COMPARATIVELY ON HEALTH CARE, OUR ECONOMIC COMPETITOR'S HEALTH CARE SYSTEMS SEEM TO PROVIDE CARE OF COMPARABLE QUALITY IN MANY INSTANCES.

YET MANY OF OUR CITIZENS ARE DENIED ACCESS TO QUALITY HEALTH CARE--LACKING HEALTH INSURANCE, EVEN ROUTINE MEDICAL CARE MAY BE TOO EXPENSIVE FOR CITIZENS OF AVERAGE MEANS. IN CONTRAST, MANY OTHER COUNTRIES' HEALTH CARE SYSTEMS INSURE UNIVERSAL ACCESS FOR ALL CITIZENS REGARDLESS OF ECONOMIC

STATUS.

THIS CONTRAST IS PARTICULARLY NOTEWORTHY IN THE CASE OF CHILDREN BORN OF POVERTY OR TO PARENTS WHO, ALTHOUGH EMPLOYED, LACK HEALTH INSURANCE COVERAGE AND ARE UNABLE TO AFFORD COMPREHENSIVE HEALTH CARE OR QUALIFY FOR PUBLIC ASSISTANCE. DUE TO INADEQUATE OR UNAVAILABLE PRENATAL CARE AND LACKING PROPER CARE DURING THEIR FORMATIVE YEARS, TOO MANY OF OUR CHILDREN START THEIR LIVES WITH THEIR HEALTH AT RISK, AND THEIR FUTURE POTENTIAL THUS IMPAIRED.

IN ORDER TO INSURE OUR NATION'S FUTURE COMPETITIVENESS, THE ABILITY OF OUR CHILDREN TO BECOME EDUCATED AND VITAL MEMBERS IN THE WORK FORCE OF THE FUTURE MUST BE PROTECTED. THE COST AND AVAILABILITY OF HEALTH CARE IS ESSENTIAL TO THE FUTURE OF OUR CHILDREN.

I LOOK FORWARD TO THE INSIGHTS THAT TODAY'S WITNESSES MAY PROVIDE, AND ONCE AGAIN, MR. CHAIRMAN, I COMMEND YOUR LEADERSHIP ON THIS ISSUE.

Senator BRYAN. Let me ask each of you a question to follow on Congressman Obey's line of questioning.

Assuming the same scope of coverage, that is, the individual insured gets the same in this system versus that system, and if I am correctly informed, that health care costs in this country are about $660 billion, which is the last number I recall seeing, which system—the mandated benefit or the national health coverage ultimately costs less, putting aside for the moment how the burden of that cost is allocated?

Mr. REINHARDT. I think the international evidence would show that national health insurance systems cost less. And the reason is pretty simple. They are controlled at three points in the money and real resource flow. First of all, they limit the physical capacity of the system with respect to high tech, such as lithotriptors, hospital beds, and so on. In British Columbia, they even limit the number of physicians who can bill under the insurance, on the theory if you ain't got it you can't use it, which works pretty well.

The English are the most extreme in that respect. Having created monopolies through these limits, they then regulate prices with price ceilings, negotiated usually but binding. There usually is no extra billing permitted. And finally, when volume runs away, they put on an expenditure cap.

Hospitals in Canada have global budgets. In West Germany, physicians as a group are given a global budget, and they distribute that to them on a fee-for-service basis.

So there is no particular miracle to this, and it is certainly true that these systems will not be quite as innovative, quite as advanced, quite as high tech and quite as luxurious as ours is, nor will the access be as instantaneous for insured people as it is here.

In Canada, you may have to wait for a coronary bypass. In England, you may have to wait quite a considerable time for elective surgery.

I think a mandated system would be more expensive still than the Canadian system, particularly if we still leave the supply side of our health system an open field for entrepreneurship, which we have decided to do. We called it "deregulation." Anyone, any three economists who want to set up an imaging unit and hire some radiologist, in most parts of the country can do that and charge, so far, whatever they like. If we continue to do that, we will have very high-tech medicine and it will be more expensive than medicine in Canada and Europe.

So, Mr. O'Neill is right. These are social choices which at some time we ought to debate a little more honestly rather than pretending these things—free choice, instantaneous access, high-tech procedures—are free. Yes, we have the most advanced system. We also pay the most. If we went the Canadian route or the West German route, some things wouldn't be quite as readily available nor would there be atriums in hospitals. And our hospitals have atriums all over the place as, increasingly, do our luxury hotels. [Laughter.]

Senator BRYAN. Mr. Maher.

Mr. MAHER. I agree with Professor Reinhardt. Clearly, the types of systems that we see abroad would be less expensive than not only the U.S. system, but if the only thing you did with the U.S.

systems, the only thing was mandate more people into it and did nothing else, that would not be a productive step.

There is one other feature of the international systems that Professor Reinhardt did not mention in his opening statement. And that is they generate considerably less administrative costs, not only on the paying side but also costs tending to be borne by the providers of care—hospitals, doctors, et cetera—that are interfacing with the system.

But I hasten to add that these international systems, there is no cookie cutter, and there is a reason that the Canadian system is the second most expensive system in the world, and that is they have controlled expenditures, one almost exclusively through resource constraint, and second, the cost of health care to the citizenry is very invisible. It is virtually all supported through the tax system. There is somewhat more, I think, price sensitivity on the consumer side in Germany and Japan because when they mandate on employees, really on citizens, the citizen also has to pay a payroll tax like FICA in the United States.

That is a contentious issue because to the extent that when they go through annual pricing negotiations in the insurance societies in Japan and the sickness funds in Germany, to the extent that that payroll tax rate has to go up, that is a bone of contention. And if, therefore, the societies in those countries are unwilling to pay that, and as a product of that they will put up with fewer atriums, that is a societal decision. And that is the beauty of having some sort of coordination and control in the system as opposed to a totally fragmented system that we have in the United States.

By the way, Senator Bryan, those countries also think they are spending too much. Germany and Japan think they are spending too much. They have, however, within their systems now, because they have some centralized control, the ability to put into place some of the micromanaging we do in this country to help assure that only effective procedures are paid for and that only the quality outcomes are supported financially.

They have the ability to put those in place with a lot more success than we do in our fragmented system. And they are going to start doing that.

Senator BRYAN. Let me just ask, Mr. O'Neill, if I might get your comment.

Mr. O'NEILL. I have difficulty thinking about the question in the way you ask it because I really don't care what my individual costs are in isolation. We have not talked about what is it we are getting for our money. It is not so clear to me that we are doing very well in that regard. If you look at the rough-and-ready indicators of health status in our country, our infant mortality rates are 20th in the civilized world.

Our system is not producing the best outcomes if you measure it in terms of general health status indicators for our population. We are falling short of the rest of the civilized world, and it may be that spending more money would give us a better value.

Senator BRYAN. Mr. Reinhardt, in response to your remark about atriums, I suppose I am a little less bothered about the atrium than I am about the valet parking service that you now find in a number of hospitals in my part of the country.

Mr. Maher, what is the attrition rate of small business? You had an interesting statistic. I believe that you said that although small businesses represent only 15 percent of the total work force, yet 85 percent of small businesses do not have insurance coverage. Did I misunderstand?

Mr. MAHER. Seventy-five percent of all the employers in the country employ fewer than 10 people. That group, I think it's somewhere around 56 percent of that group don't offer health insurance.

In the aggregate, I think 46 or 47 percent of all employers in the United States don't offer health insurance. That group, however, employs a relatively small amount of the work force, roughly 15 percent. And there is a lot of ins and outs of employees into that system.

In other words, the recent census data, while it suggested that during 1988 or 1989 that 12 or 13 percent of the population did not have insurance, roughly 32 million people, however, when you look at a 28-month study, that only roughly 71 to 72 percent of the population had insurance either publicly or privately provided during that entire 28-month period, and it represents a lot of the comings and goings and part-timers in the small business community.

That is a problem that I think we have to cope with if we decide to continue just an employment-based system, because you are just going to have the two-income family, ins and outs in the employment sector.

Senator BRYAN. Let me try to focus a little more narrowly on the question. Aren't we likely to see some sort of an attrition rate? Small business has been, as a category, among the most resistent to the mandated benefit approach, whether you're talking about this, family leave, or a host of other societal problems that we are dealing with at the Federal policy level.

Is their concern unduly magnified? Listening to them, it's my feeling that they honestly believe that it's going to drive them out of business. Some of them are simply not going to survive. If you think there is any truth to that, how much, and what numbers are we likely to see?

Mr. MAHER. First, I think you've correctly described their point of view. A lot of these, and I think it's like 60 percent, are four or fewer employees. And many times the proprietor doesn't have it.

Senator BRYAN. So he or she can't afford it.

Mr. MAHER. So their mindset is, correctly so, that this represents a 30-percent increment or whatever on my payroll costs, I can't handle that. That is, I believe, their honest evaluation.

Now, frankly, whether or not if they all had it and the price of dry cleaning a shirt went up 6 cents and the price of a Big Mac went up 11 cents, whether that would—and the elasticity of demand could handle that and everybody would go on, you know, we'd have to see that.

All I would suggest is that in the German and Japanese system that corner dry cleaner has a payroll tax that they have to pay. Everybody does. Now, if it's a low-wage concern, obviously the payroll tax is not going to generate enough dollars that would have bought that person an insurance policy because there are cross subsidies going on in the system.

So to that extent, whether you raise it by having a payroll tax on the low-wage industry, how that would impact the cost to that firm versus an income tax on the firm, I haven't seen a model. You know, it may be an insignificant difference between the two. Clearly, though, if they had to go see their friendly insurance agent and buy a policy, that blows their mind.

Senator BRYAN. Mr. Reinhardt, any comment on that?

Mr. REINHARDT. I am delighted to hear my colleague, Mr. Maher, talk about price elasticity. That brings me back home. He is one of us. [Laughter.] Incidentally, he asserted earlier that I teach health economics at Princeton and therefore might be wasting my time. I do not teach health economics there. I earn my money the hard, old-fashioned way. I teach accounting, finance, and economics. In other words, I earn my keep at Princeton the old-fashioned way.

But the point is surely this: That if you laid a mandated benefit on business, which is $3,500 per employee on average, the workers who now make, say, $14,000 a year, that would be a sizable increase in payroll expense for a small business.

Now, the probability of shifting that cost increase forward would depend very much on the price sensitivity of whatever these firms are selling. Suppose you did this to all the Burger King's and all the MacDonald's, et cetera. One might make the argument that, OK, the price of hamburgers will go up maybe 15 to 20 cents and people would just eat it—the price hike, that is—they would buy the hamburgers nevertheless. On the other hand, it could also be that there would be a dropoff in demand, in which case it is indeed a problem for small business. The answer to this really is not so clear. It is a purely empirical question.

If you, however, put this burden onto a business that has foreign competitors, then it may not be possible to shift forward any of that cost increase through higher prices. The firm could not shift it forward unless the foreign competitor has those same costs, which they would not. In that case it would have to be shifted backward to the worker. So instead of paying a worker now $14,000, you pay him $11,000, and there would come a level of cash take-home pay so low that a worker might decide not to work at all.

So at the fringes a mandate could create these types of problems.

Senator BRYAN. Those are pretty uncomfortable policy choices.

Mr. REINHARDT. They are indeed.

Mr. MAHER. Right now, though, what is going on is, in the absence of the employees in the small business community being covered—and they are typically low-wage persons—we are a humane society, that person gets sick enough, they are going to go to a hospital, they are going to get treated, and the cost is going to be absorbed in the system by the companies like ALCOA and Chrysler, who are already paying, in my judgment, for an excessive amount of care, through a very sneaky type of tax.

Senator BRYAN. In addition to that, the general taxpayer, at least in publicly supported and financed hospitals, in effect pays a certain amount for medical indigency, and that number goes up. Most public hospitals in the country are constantly dealing with county commissioners, city councilmen, hospital district administrators, whatever the level of local district control and whatever the share of the ad valorem or whatever the basis is.

Mr. O'Neill, you were about ready to enlighten us.

Mr. O'NEILL. I was about to say that a good test of how seriously we want to do mandates is to say that we are going to put the mandates directly on people who work in small businesses and find out whether they really want that. It would really be a very good test.

If we said to people who are making $10,000 a year, "From now on, you must pay $3,500 a year for health and medical care." Then we would find out what the economics of competition are, especially in cases where we have foreign competition. I can tell you by direct experience what happens: The work goes to Mexico. It is not a curious thing; it goes to Mexico.

Senator BRYAN. Let's talk just for a moment about costs before the chairman returns.

You made the point, Mr. Reinhardt, that at least in a national system there is enormous leverage—I don't think those were your words, they were mine—for example, you can control a lot of things, you can pretty well dictate what the contract prices are that the providers are going to get, you can provide a certain pool of money and say that you are allocated no more.

Mr. Maher, if I remember correctly, the German system is somewhat akin to that where they set aside so much money, it's a fee-for-service system, but in effect you cannot exceed the overall allocation itself. Let's put this cost equation in a context of a mandated benefit approach. I hear a lot of folks who are saying to me, well, I don't like mandated benefits, people particularly in the business community, for the reasons we have just suggested. But if you have a mandated benefit and no kind of cost control, you have the worst of both worlds.

Philosophically I don't like mandated benefits. I resist that solution, although I recognize that there is a social problem out there when you have 37 million Americans that we all talk about, and perhaps another 24 to 27 million Americans who have nominal insurance. The latter group are so undercovered that it provides a gap that I think most of us would recognize we need to address in some fashion.

But what about the cost equation, how do we control that in a mandated benefit approach?

Mr. REINHARDT. As I said earlier——

Senator BRYAN. I apologize. I was not here.

Mr. REINHARDT. Oh, sorry. I understand.

You have to have an all-payer system in the end, or a mandated approach would collapse. Small business would not accept to be mandated to buy health care at a rate that is 20 percent higher than what Chrysler pays. They wouldn't pay that. Neither should they or would they accept this.

And so I feel, whether the American Medical Association likes it or not, they should get ready for the day toward the end of this decade where this country will have an all-payer system. That is that every payer to the same hospital pays the same rate for an appendectomy and the same doctor pays the same fee.

Now, in hospitals we already have this in New Jersey, and it works. Therefore, we do not have an indigent care problem in hospital care in New Jersey. No hospital would ever turn away an uninsured patient, because we have an all-payer system. And I know

there is tremendous ideological opposition to this, but sometimes I would urge providers exploit the inevitable, get ready for it because it will come.

Senator BRYAN. Mr. Maher, your comments?

Mr. MAHER. If the purpose of the mandate was to address the Nation's access-to-care problem, the uninsured problem, and therefore the mandate is going to be part of the solution together with expansion of public programs through Medicaid——

Senator BRYAN. Don't you think if we go to that, that is the only premise upon which we ought to proceed? Universal access? I think most people would accept that as a practical thing.

Mr. MAHER. If that is the practice, then the Congress has to realize—and the reason we are doing that is that as we look around the world, we say this is atrocious, it's an embarrassment to our country. No other country has granted access to care for all their citizens and created a process to deliver that without concurrently putting in place a system to keep from breaking the bank.

They have a system in place to help manage the control of aggregate national expenditures. Some do it in different ways, but they could never have delivered on the first piece of that without doing the latter.

Senator BRYAN. Do you agree with Mr. Reinhardt that the all-payer system is the way to go?

Mr. MAHER. Yes, I do.

Senator BRYAN. Mr. O'Neill, your comments?

Mr. O'NEILL. I think even in my notion of direct mandates on individuals, and the society making that promise good for low-income people, it is inescapable that there has to be with that mandate, some kind of control.

I think in that system you need less control than if you are effectively encompassing everything in the health and medical care system in your notion of an all-payer system. I think we could get away with limiting facilities and probably stay at the procedure level of price regulation. But if we go to something beyond that, we are doomed to end up with a Federal wage-and-price control system for our health and medical care in this country.

Senator BRYAN. What, from your point of view—obviously you are uncomfortable with going that far—what kind of price or cost control mechanism do you think you would prefer?

Mr. O'NEILL. I would work toward the notion of a basic level of health and medical care mandate for people, and then I would use the ideas that are in the process of being tried in Oregon, to try to differentiate between those things that are in the basic care package and those that aren't.

For those that aren't, I would like to let the price mechanism work. That is to say, if you have enough economic wherewithal and interest in having more health and medical care than what you are mandated to have by the society, I would let you go buy it and I wouldn't care what you paid for it any more than I care how much you pay for your automobile or your food.

Senator BRYAN. Accepting that for the sake of argument without conceding its merits, how about the basic package? You bifurcate the package and you say there is a basic package and then there is the nice-to-have?

Mr. O'NEILL. I do. And I suppose I would make some fairly difficult social distinctions. It is not so clear to me that the society should pay for a lung transplant for someone who smoked for 40 years. They may not like to hear that, but, in the real world of setting priorities—if we are serious about setting priorities—those are some of the kinds of issues that we need to deal with and the way we are headed now they are all swept under the rug.

Senator BRYAN. I am not sure I am hearing an answer. Making those distinctions that you are making, again without conceding whether they are right or not——

Mr. O'NEILL. If you look at the Oregon plan, if you look at what they are doing, it is trying to define a rational set of services that people are entitled to that, in effect, describes a cost profile for the whole population. And if we have that kind of a notion across the country, we would probably have a basic coverage package.

Help me a little bit, Mr. Reinhardt. Maybe $2,000 or $2,500 would be the cost for an individual if we left out the atriums and the chauffeurs and all the other things in our definition of a basic package.

Mr. REINHARDT. Yes. Of course, the atriums, you have to buy them with the ICU if you're going to a hospital that has an atrium.

Mr. O'NEILL. But that's a consequence of where we have been. If we said as a matter of national policy that we the people will pay for an eight-bed ward—and there is a difference between an eight-bed ward and a semiprivate or a private room and the atriums and all the rest—we would have a different set of providers than what we have now. We have what we have now because it's all folded into a third-party payment system and you never feel you paid for the chauffeur. You do, but you never have to face the issue directly.

So I think if we were willing to explicitly address what it is we want for our society, we could define a set of basic things and then we would have to have some control over them and we would have to have some insistence on what we do, for example, with a 50-percent excess hospital bed supply, if we are going to have a chance to make this two-tier system work.

Senator BRYAN. What I think I understand you to say, in that basic package, however we define it, with the sociological distinctions that you have drawn between the individual who may have inflicted some of his own medical problems upon himself by virtue of 40 years of smoking, do you still then have the unlimited payment to hospitals and to physicians? Are there any constraints in the dollar amount for whatever that basic package is? You say, "Look, whatever the freight can bear you can charge." Or do you have to either set a fixed rate of compensation? Do you have to put a total cap in terms of the resources made available for that basic coverage?

Mr. O'NEILL. As I said, I think you have to have some level of control over procedures, but I think maybe we can escape setting a physician's compensation level of $75,000, for example, which is where I think we get to with these other notions. I think at the end of the day all of these procedural things and DRG's and the rest are not going to work, especially if we have all of these things embraced in some sort of national system.

We are going to have to end up saying, in effect, the medical system works for the Federal Government, we will just set your compensation the way we do for people who work for the Government.

Mr. MAHER. Let me just follow up on that. Let's assume we do exactly what the two of you have been discussing. We settle on a basic level of benefits, and if you assume that we are going to continue with the public sector through Medicare and Medicaid——

Mr. O'NEILL. I don't.

Mr. MAHER. In my answer, I am going to assume that Congress is not going to abolish Medicare and Medicaid or maybe merge them. But assume for the purpose of my argument it is essential, for at least this theory, that we have a continued public presence. Now, that public program has entered into a pact with the business community. We are going to pay fairly. We are not going to cost shift to you. So now the public program has to decide and define its obligation to the set level of services what is a fair price. That is done, and everybody agrees that is a fair price. There is no cost shifting inherent in that.

Now, you shift to the private sector program. Why should the private sector, apart from perhaps some HMO dealings or maybe they want to even hire a doctor or buy their own clinic, as long as there is no cost shifting involved in what the private sector is going to do, why would the private sector want to pay any more?

Why should the Federal Government permit the private sector to pay less, having been hammered into surrendering their ability to cost shift, if there is a fair price? That is what I am saying. It almost drives you on a unit price basis to some type of coordinated all-payer system where a Chrysler would pay no more or less than Medicare and no more or less than Joe's Tool & Die.

Mr. BYRAN. Mr. Reinhardt.

Mr. REINHARDT. We will be facing this issue. I also believe that the issue of pricing health care needs to be faced more openly. We are not talking about Government-set prices. We are talking about negotiated prices. Most other countries negotiate prices. The only place that uses Soviet-style pricing so far is America's HFCA via-a-vis hospitals. We may call HCFA's appoval "pre-Glasnost" pricing. That is, the Government sets prices—the DRG updates—that every hospital has to take. That is not a negotiated set of prices. I find it significant that the most promarket President we ever had was the first one to use that kind of pricing, an administered pricing system, when he presided over Medicare. Furthermore, he did the same for doctors when he froze their fees. That tells you something about how well he could make the market work. There has never been any attempt made by either the Reagan or the Bush administration to use market forces in the health programs over which they presided.

I think we will soon face an interesting national experiment—in 1992. By that time, the Physician Payment Review Commission, on which both of us serve, will have readied the resource-based relative value scale for physicians, which will raise prices for primary care physicians and substantially lower those for ophthalmologists, radiologists, thoracic surgeons, and so on.

I can predict that the Business Roundtable will then do three things: First, it will scream about cost shifting by Government, because they will argue that when thoracic surgeons cannot obtain their revenues from Medicare patients, they will stick it to business. That's the first statement to come from the Business Roundtable.

Next, the Business Roundtable will curse the Government for regulating prices. They will say, "It's Government regulation again that is messing up the health care system."

And the third, of course, the Business Roundtable will ask for cuts in social spending. That is a permanent request from that Roundtable. All of this adds up to which I referred to earlier as "intellectual bankruptcy."

Senator BRYAN. One thing I think we can all agree with is that the health care system as we know it today will not be the same kind of health care at the start of the next decade. Sometime there is going to be substantial change.

On that note, the chairman has indicated he is going to return momentarily. I have to go to a meeting on the other side. We will stand in recess until Chairman Hamilton returns.

Gentlemen, I thank you very much.

[A short recess was taken.]

Representative HAMILTON. The Joint Economic Committee will resume its hearing. I apologize to you for the recess, although I understand it hasn't been too long. The Senator just left, and I will wrap it up because I know your commitments are pressing you.

We had two votes, not one, on the floor. That is why I was detained a little bit.

Just a quick impression I want to get from you. The health care issue is becoming a bigger issue, is it not, in labor-management relations? My impression, in talking to people, is that workers today put this health care issue right at the top of the agenda. Is that correct?

Mr. O'NEILL. Agreed.

Representative HAMILTON. And that is not likely to let up.

Mr. Reinhardt, you said in your opening comments that business must confront the agony of health care, and I got the impression you were going to let them stew for a while on the question. I am under the impression they have been confronting that agony for some time and they are really wrestling with it. I am not sure I quite understand your comment.

Mr. REINHARDT. The thrust of my argument has been that it is safe to let them eat for awhile the stew they cooked, because that repast will not erode the competitiveness of American industry. It just will make labor-management relationships tougher and more cantankerous. During the 1980's, American executives have talked a tough game in health care, but they really have not done much at all.

Representative HAMILTON. You don't think they're a very good consumer?

Mr. REINHARDT. No. They are very lax, very careless purchasers of health care.

Representative HAMILTON. Is that your impression, Mr. O'Neill?

Mr. O'NEILL. I think it varies. I think in the case of ALCOA and Chrysler, we have demonstrated that we have an ability to shift costs more than those who spend less time working at it. It's not the right societal answer. The fact that we can shove it off on somebody else doesn't make it right, make it good, or make us smart purchasers.

Representative HAMILTON. Are you paying $8,000 to $10,000 for a procedure that you ought to be paying $3,000 or $4,000 for?

Mr. O'NEILL. I don't know the reference that Mr. Reinhardt gives. I doubt it, but I can't say absolutely not.

Representative HAMILTON. On the proposal that I think you, Mr. O'Neill, and Mr. Reinhardt made, I am not sure I understand it. You say that a better approach is to mandate health insurance coverage for individuals. I gather by that we would pass a law up here saying every person in America ought to have health insurance.

Mr. O'NEILL. And you would specify what it covered.

Representative HAMILTON. And we would specify the coverage. And then you, as a corporate executive, I presume, would adjust your plan with that proposal, and employers across the Nation would?

Mr. O'NEILL. It's complicated what we would need to do. But we would need to insist on regional rating for insurance, and then I think it makes sense, as part of the employment connection, to collect premiums as part of the compensation process and send them off to the regional insurance agency.

But, in effect, we would be an administrative agent for the individual and the pooling mechanism, and that is the responsibility we would have.

Representative HAMILTON. You would work it out.

Mr. Maher, how do you react to that?

Mr. MAHER. That is not terribly different from the Japanese and German system. The systems, in effect, require all citizens to have coverage, but concurrent with a process to facilitate the collection of dollars that pay for it and a mechanism for the construction of benefit plans, quasi-insurance systems, to deliver the benefits to them.

All citizens have to pay a payroll tax.

Representative HAMILTON. Let me just ask you this more directly: Do you react positively or negatively to that proposal?

Mr. MAHER. I think it's not terribly inconsistent from my view. You can't just go out and say everybody has to have insurance, period. You have to concurrently establish a framework so that these citizens now will be able to go out and afford to buy coverage that is affordable.

Representative HAMILTON. Of course, we then here would immediately have the problem of what the fail-safe system would be, wouldn't we? How far up the income ladder you would go. Is that right? Have you thought that out, Mr. Reinhardt?

Mr. REINHARDT. I think I have. This fail-safe system would be tax financed, in my scheme, income tax financed. On your 1040 it would say health insurance tax, say, a tax rate which would be progressive with income. If you have an income of $14,000 or less, it's free or a very small premium; if you make $30,000 or more, that tax could be 12 percent.

Representative HAMILTON. But you would draw a line, everybody below it gets free, everybody above it pays?

Mr. REINHARDT. Yes. We would have a progressive tax so that the cost of the public plan would increase steeply as individuals go up the income scale.

Representative HAMILTON. As you go up the income ladder?

Mr. REINHARDT. Yes. Now, there would be many people who don't pay into the system. Therefore, I would have to ultimately ask people to pay an earmarked indigent-care tax, which is basically that is what it means to be in America. One would have to see if we still are a nation in that sense or not. I suspect we probably would be. I think such a tax of about 1 percent we calculated would do the trick.

The way this would go is as follows: If you have a private policy, you would just clip it to your 1040. You wouldn't pay, say, 12 percent of your income for the fail-safe program, which is what it would cost, but only 1 percent for the indigent-care pool.

Representative HAMILTON. Have you spelled this out in a paper?

Mr. REINHARDT. It's spelled out in a one-page article in the Wall Street Journal, very simply.

Now, what happened when I proposed this scheme is that people would say, "But now you're shifting costs to the private sector because the fail-safe system would negotiate rates at the State and local level." And that is how the all-payer idea came up. Sure, a big Government buyer can shift costs to the private sector, and if private sector people don't like it, let them come on board of the public reimbursement system.

For instance, even ALCOA in 1992 could offer its employees a Medicare fee-schedule option where it would tell its employees, "If you go to the physicians who accept the Medicare schedule, we will pay 100 percent of your health care costs, but if you insist on the open-ended system, you pay 30 percent out of pocket." They could do this, and they could similarly come on board my fail-safe system if they wanted to.

The reason I like my system, that doesn't mandate health insurance on small business. It is very flexible in administration. You can make the private and public's part just about as big or small as you want, depending on how you set the tax rate. Ultimately, if business wants an all-payer system, let them come to the table. I wouldn't ram it down their throat, as I said; I would let them suffer a bit of fiscal agony first.

Representative HAMILTON. OK. I think you and I both have to conclude here.

Thank you very much for your participation this morning. You have been very, very helpful.

The committee stands adjourned.

[Whereupon, at 12 noon, the committee adjourned, subject to the call of the Chair.]

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